The Music Therapist's Experience of the Client-Therapist Relationship in Improvisational Voicework: An Interpretive Phenomenological Inquiry

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THE MUSIC THERAPIST’S EXPERIENCE OF THE CLIENT-THERAPIST RELATIONSHIP IN IMPROVISATIONAL VOICEWORK: AN INTERPRETIVE PHENOMENOLOGICAL INQUIRY

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

by
Samantha Schick, MT-BC
Molloy College
Rockville Center, New York
2021
MOLLOY COLLEGE

The Music Therapist's Experience of the Client-Therapist Relationship in Improvisational Voicework:

An Interpretive Phenomenological Inquiry

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Samantha Schick, MT-BC

A Master's Thesis Submitted to the Faculty of

Molloy College

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Abstract

The voice as it is used in clinical improvisation in music therapy can impact the therapeutic relationship between the client and therapist. This study sought to explore music therapists’ perceptions and experience of the client-therapist relationship in the context of improvisational voicework through semi-structured interviews with two experienced Nordoff-Robbins music therapists. The research questions included: What is the music therapist’s experience of the client-therapist relationship in using the voice improvisationally? What is the possible impact of vocal improvisation on the therapeutic process overall? Through an Interpretive Phenomenological Analysis of the data collected in the interviews, three superordinate themes emerged: 1) The Vulnerability of the Voice, 2) Intentionality in Singing and the “Creative Now,” and 3) The Music Is Enough. Findings of the study imply that voicework and vocal improvisation play an important role in the development of the therapeutic relationship in music therapy. The use of the voice can enrich the therapeutic relationship by creating a pathway for communication between the client and therapist that might not otherwise exist. It may also be a unique means of expression for the client. Further research is needed to explore the role of vocal improvisation and voicework in developing the therapeutic relationship across theoretical approaches and client populations.

Keywords: voicework, vocal improvisation, singing, therapeutic relationship, client-therapist relationship, music therapy, Nordoff-Robbins
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Introduction

This study explores music therapists’ perceptions and experience of the client-music therapist relationship in the context of improvisational voicework, through interviews with two experienced music therapists who utilize improvisational voicework in their music therapy practice. The data collected in these interviews were analyzed using the protocol outlined for an Interpretive Phenomenological Analysis (IPA) to explore the relationship between improvisational voicework and the therapeutic relationship. My epistemological stance is interpretivist, in that I believe that truth is subjective and can be interpreted based on an individual’s experience and perceptions of a phenomenon. Accordingly, interpretivist research “assumes that reality and truth are multiple human constructions, rather than objective absolutes” (Bruscia, 2016, p. 54).

My work in music therapy throughout my graduate studies has led me to view the voice, which I consider to be my primary instrument, in a different light. My experiences of the versatility and diverse functions of the voice in music therapy led me to feel inclined to study this phenomenon further as it relates to the therapeutic relationship. As a first phase Analytical Music Therapy trainee working within a Nordoff-Robbins framework at my internship, I became intrigued by the impact of the voice in improvisation across different therapy approaches. The founder of Analytical Music Therapy, Mary Priestley, described this approach as “the analytically-informed symbolic use of improvised music by the therapist and client. It is used as a creative tool with which to explore the client’s inner life so as to provide the way forward for growth and greater self-knowledge” (1994, p. 19). Nordoff-Robbins Music Therapy is defined as “a music-centered approach built on the belief that every human being has an inborn capacity to find meaning in musical experience” (Nordoff & Robbins, 2004, 2007, as cited in Birnbaum,
2014, p. 30). With an emphasis on improvisation, this approach aims to “use music to access and develop the strengths within each individual -- in a sense, creating the musical environment where a client is intrinsically motivated to engage, interact, learn, grow, and develop” (Nordoff & Robbins, 1965, as cited in Markworth, 2014, p. 5). Both approaches will be discussed in greater depth below.

In my work and training, as both a client and music therapist, I have experienced the ability of voicework to strengthen the therapeutic relationship, in the interrelatedness of musical experiences between client and music therapist, reciprocity of musical interactions, and progress toward musical and non-musical goals. Throughout my experience as a fieldwork student and intern, I have observed and implemented the therapeutic use of the voice in a variety of interventions.

In my fieldwork placement at an acute psychiatric unit, I witnessed the use of vocal improvisation as a tool for both connection and healing. Patients would often freestyle rap about their experiences during improvisation, which would often lead to musical interactions among group members and the music therapist. The use of the voice also allowed the clients to express themselves through making various sounds and vocalizations. In addition, breathing experiences brought an awareness to the breath that appeared to help the patients center themselves and relax in the moment.

In my internship placement at a center for children with various developmental delays and challenges, I used improvisation regularly. My supervisor and I worked within a music-centered, improvisation-based framework following many of the tenets of Nordoff-Robbins music therapy. We generally utilized the co-therapy model of the Nordoff-Robbins approach, wherein one music therapist provides the musical framework for the session while the other
facilitates the clients’ participation in musical activity and interaction (Nordoff et al., 2007). In this work, I used my voice improvisationally with increasing frequency. I came to recognize that significant progress toward clinical goals can occur through unaccompanied voicework and that instruments are not always needed. I was able to connect with clients more authentically as we sang together a cappella, and learned that the voice alone is more powerful than I had realized. This could be seen through conversational vocal improvisation, the use of familiar songs, or vocalizations that reflected the clients’ expression and thus made the music more inter-responsive. I found that vocalizing on a vowel or singing the melodies of familiar songs could elicit a vocal response from clients who were otherwise “non-verbal.” These vocal “conversations” or “fill-in-the-lyric” instances became more frequent and more relational as the work progressed. The musical interactions appeared to strengthen the client-therapist relationship through building trust.

As part of my Analytical Music Therapy training, I also experienced the therapeutic impact of the voice as an Analytical Music Therapy client. In working with my Analytical Music Therapist, I found that it is both difficult and powerful to improvise with the voice. While improvising with the voice as a client made me feel most vulnerable and raw, it also made me feel most understood and validated.

These experiences and observations have led me to wonder whether the vulnerability of using the voice impacts the therapeutic relationship in music therapy. Through the use of the voice in improvisation, one essentially is the instrument. Research has shown the profound impact voicework can have on the therapeutic process, in that “…the most healing connections seem to occur through the voice” (Austin, 2009, p. 19). It is important to examine this phenomenon as it is experienced across improvisational frameworks in music therapy because it
could better inform our practice and use of vocal improvisation. Such research can potentially strengthen and broaden the use of the voice in music therapy to develop the therapeutic relationship and address specified goal areas in a variety of contexts.

The following research questions will guide this thesis study:

• What is the music therapist’s experience of the client-therapist relationship in using the voice improvisationally?
• What is the possible impact of vocal improvisation on the therapeutic process overall?

**Literature Review**

**The Voice as a Therapeutic Tool**

Singing and voicework can provide clients with opportunities to express themselves, release emotions, and connect feelings to sound (Austin, 2009). When we sing, we are vulnerable in that we are the instrument in the truest sense: “The process of finding one’s voice, one’s own sound, is a metaphor for finding one’s self” (Austin, 2009, p. 21). Austin (2009) poses the question “Why is singing such a powerful experience?” (p. 20). She suggests it may be because, in singing, “we make the music, we are the music” (p. 20).

Austin maintains that the breath plays an essential role in reconnecting the body to the voice and expressing feelings and emotions: “There is reciprocity between the physiological and psychological effects of breathing” (2009, p. 25). In Austin’s view, shallow breathing reflects an unconscious effort to control and suppress emotions. She believes that “the way we breathe influences how we feel, and what we feel has a direct effect on how we breathe” (p. 26).

Priestley (2012) remarked on this as well, stating that “many people whose emotional disturbance is based on the feeling of having been rejected, retaliate by refusing to make a full exchange with the world by means of breathing. They snatch at the minimum amount of air with
shallow chest breathing” (p. 79). By participating in vocal groups and expressing themselves through singing, people can “let the world in, with deep breaths, later with sighs, laughter and singing” (Priestley, 2012, p. 79). This implies the importance of examining not only the voice as it is used in music therapy, but the breath as well.

The therapeutic use of the voice has also been found to enhance overall health, such as by stimulating endorphin release, relieving stress, and boosting the body’s immune system (Austin, 2009). Priestley (2012) believed that singing in a group could be beneficial by providing patients and clients with a supportive environment. She stated that “an important aspect of singing is its possibilities in rehabilitation,” in that it could help patients work towards “overcoming feelings of alienation and loneliness” (Priestley, 2012, p. 79).

Austin’s work was greatly influenced by Jungian psychology. Jung believed that the self and the ego are one in the unconscious at birth. Jung described the ego as the center of consciousness that is impacted by the self. Its function is to oppose the self or to carry out its will (Marlan, 2006). As one moves toward consciousness, the two split and parts of the personality withdraw from consciousness (Austin, 2009). The key elements of Jung’s framework include the collective unconscious, archetypes, and the concept of transference and countertransference reactions. Austin analyzes these elements in her vocal psychotherapy work with clients and has found characteristic tendencies in the music of clients who are playing out trauma complexes in the music. Jung defines a complex as a psychic fragment that has disconnected from the self as a result of trauma. Austin states that “the split-off dissociated parts that inhabit the inner world of the traumatized client are often externalized in the client-therapist relationship” (2009, p. 64). She observed that the music of clients playing out a trauma complex tends to have a quick tempo, repetitive structure, and compulsive quality (Austin, 2009). Through studying trauma
theory and Jungian psychology, and working with clients in a vocal psychotherapy framework, Austin (2009) has found that “music can enable clients to connect to authentic feelings” (p. 44).

Object relations theory has also contributed to Austin’s work in its emphasis on interpersonal relationships and the impact of past relationships upon present relationships (Austin, 2009). Austin has found that vocal improvisation provides an opportunity for clients to be spontaneous in exploring and experimenting with the self, within the safe and supportive client-music therapist relationship. In time, this can lead them to respond to old situations in new ways. Austin expresses the hope that through vocal improvisation in psychotherapy, her clients “can take what they learn from vocal improvisation into their lives” (2009, p. 56).

The Client-Therapist Relationship in Music Therapy

Regarding vocal psychotherapy and the therapeutic relationship, Austin (2009) states that “the music, the sounds and the singing facilitate the client-music therapist relationship” (p. 193). As the client-therapist relationship develops and the client comes to trust the music therapist more deeply, the client may be inclined to take more risks and reflect their true selves in their singing, vocal improvisations, and lyrics (Austin, 2009). As cited above, Austin drew upon the key tenets of Jungian psychology, trauma theory, and object relations theory in developing her vocal psychotherapy framework and conceptualizing the therapeutic relationship (Austin, 2009).

Other researchers have also documented the impact of musical interactions on the client-therapist relationship in music therapy sessions. Cole (2003) explored the concept of “musical meetings” in the development of the client-music therapist relationship in music within a humanistic approach to music therapy with children with disabilities. Cole (2003) stated that “each musical meeting…or establishment of musical relationship is important to the functioning
and survival of these children” (p. 90). Analysis of her experiences in sessions allowed for insight into the client-music therapist relationship, finding that “the relational moments…can be seen as therapeutic goals” in themselves (Cole, 2003, p. 87). Cole concluded that the significance of musical interactions for clients with disabilities encompassed “not just their improved communication skills…but their ability to come together with someone through music in a way that allows them to be a part of what it means to not only survive, but to live” (2003, p. 90).

In Nordoff-Robbins music therapy, many aspects of the therapeutic relationship are formed through improvisational music experiences: “Nordoff and Robbins emphasized the importance of a genuine human relationship between music therapist and client, by creating musical experiences together” (Birnbaum, 2014, p. 30). The Nordoff-Robbins approach reaches clients through their basic musical beings, and from this foundation builds the client-music therapist relationship. As Birnbaum (2014) observes, “the relationship seen in the music can be seen as an intersubjective field, the shared space in which communication and growth can take place” (p. 30). This approach thus supports an intersubjective perspective, with “a view of therapeutic relationships as interpersonal fields of musical communication” (Birnbaum, 2014, p. 36), as in the “musical meetings” described by Cole (2003, p. 90).

Working within a psychodynamic framework, Di Franco (2002) conducted a case study of improvisation with a child with Autism Spectrum Disorder. Regarding the role of music in the therapy, Di Franco (2002) observed that through improvisation, the client “was slowly entering the relationship with me, and also with himself, giving the impression that he was making more meaningful contact with his inner world” (p. 100). This study provides insight into the impact of improvisation on the client-music therapist relationship within a psychodynamic model, in terms of relatability and social interaction (Di Franco, 2002).
These studies and perspectives on the impact of vocal improvisation on the client-therapist relationship emphasize that (a) singing enriches the therapeutic relationship in the music, (b) singing furthers understanding of the client by meeting them in the music, and (c) improvisation is a valuable tool for communication between the client and music therapist.

**Improvisation in the Music Therapy Process**

*Vocal Improvisation and Mental Health*

Iliya (2011) conducted a study of voice-centered music psychotherapy methods that she utilized with patients with mental illness. In her view, “vocal music psychotherapy may benefit this population more than traditional verbal psychotherapy alone because of the unique benefits of using the voice in a therapeutic context” (Iliya, 2011, p. 14). Voice-centered music therapy is highly accessible to this population in that “producing vocalizations is innate to humans and is, therefore, highly accessible to clients in the music therapy setting” (Iliya, 2011, p.15). Working with the voice allows the clients to express themselves in ways that other methods of therapy may not allow: “Within the structure of singing, a person may be able to organize and express a fuller sense of self on many different levels” (Iliya, 2011, p.16).

The vocal methods employed in this study included group singing, toning, and group and individual vocal improvisation with patients who were homeless and mentally ill. Iliya (2011) found that vocal work allowed her “to meet [clients’] needs…but also to establish and nurture genuine relationships” (p. 22). The use of the voice in music therapy allowed for social and expressive interaction between client and music therapist, and among clients. Iliya’s findings suggest that further research is needed to explore the role of voicework in the treatment of this population.

*Vocal Improvisation in Medical Settings*
Vocal improvisation in music therapy has also been utilized and studied in medical settings. Clements-Cortés (2017) studied vocal improvisation in both palliative and cancer care, finding that “through vocal improvisation, a person in palliative or cancer care may experience psychosocial or emotional benefits” (p. 340). Music therapists who participated in her study observed that their patients “felt lighter and could express themselves through their singing and sounds without having to justify what they were feeling in words” (p. 354). The study concluded that although vocal improvisation was not the most commonly used vocal method in this setting, it proved to be a uniquely valuable intervention for patients (Clements-Cortés, 2017).

Turry (2007) examined the relationship of words to music in improvisational songwriting with a client diagnosed with cancer. He observed that improvisation provides patients with the opportunity to express themselves and explore their emotions through music, and that a Nordoff-Robbins music therapist using improvisation in a medical context “can help the client express thoughts and feelings in music that are difficult to express verbally” (Turry, 2007, p. 36). In the study, vocal improvisation and song lyric creation gave “voice to [the client’s] emotion” (p. 36) in a way that other methods of treatment could not. The client in this study improvised and sang about “finding her true voice” as part of her process of coping with her illness through music therapy (Turry, 2007, p. 36). In reflecting on this client’s therapeutic process, Turry references Austin’s concept that singing helps traumatized clients feel their strength and authentic voice (Austin, 2001, as cited in Turry, 2007). Improvised singing helps clients to embody emotions such as anger, sadness, and confusion, and therefore allows them to feel and process their emotions without having to verbalize them.

*Improvisation with Children with Developmental Delays and Challenges*
Many studies have explored improvisation as a musical intervention with children diagnosed with Autism Spectrum Disorder (ASD). According to Geretsegger and colleagues (2015), “improvisational methods of music therapy have been increasingly applied in the treatment of individuals with ASD over the past decades in many countries worldwide” (p. 259). Improvisational work with this population involves key principles that remain constant across different theoretical models of music therapy practice (Geretsegger et al., 2015). These key principles include musical scaffolding of the flow within interactions between the client and music therapist, and facilitating experiences that promote emotional and musical attunement for the client (Geretsegger et al., 2015).

Music therapy provides a context and a framework for emotional and musical attunement by scaffolding social reciprocity, increasing self-awareness, and improving communication skills. Improvisation allows music therapists to create moments of musical attunement that may reflect a child’s focus, emotional expression, or behavior. By bringing attention to these aspects of a child’s presence and expression in music, musical attunement may potentially lead to emotional and affective attunement in interactions outside of the music therapy context (Geretsegger et al., 2015). This is significant for clients with ASD, whose developmental challenges are characterized by difficulties in social and emotional communication and interaction. Creative musical interaction is the basis for establishing the musical relationship and addressing musical goals (Clements-Cortés, 2019). Co-active improvisation allows the music therapist to become immersed in the client’s experience so that the therapist can “begin to see the world through their own eyes” (Birnbaum, 2014 p. 35).

Studies focusing on the Nordoff-Robbins approach to music therapy have shown that improvisation engages clients with ASD in many ways. Markworth (2014) explored the
communicative nature of improvised music in sessions conducted by three Nordoff-Robbins music therapists working with children with ASD, extracting themes that included “Music Language,” “Musical Expression,” and “Music as a Shared Experience”. Each music therapist in this study learned the “music language” of their client and framed their music accordingly, in order to communicate that the child was heard and understood. The study references the concept of the “music child,” which is one of the key tenets of Nordoff-Robbins music therapy. This concept maintains that every child is innately musical and is thus “capable of meaningful interaction and shared experience through music” (Nordoff & Robbins, 2007, as cited in Markworth, 2014, p. 5). With this concept in mind, the music therapists used music as a means of expression that could be understood without the need for spoken word. The study found that for all participants, music played an essential role in developing the therapeutic relationship. As Markworth (2014) observed, “the clients joined the music therapist’s music by matching pitch while vocalizing, imitating rhythmic motives, and establishing eye contact while experiencing a pause in the music” (p. 33). The findings suggest that these elements of musical interaction are “musical representations of the therapeutic relationship” (Markworth, 2014, p. 33).

Improvisational music therapy methods to address the goals of children with ASD have also been implemented and investigated within a psychodynamic framework. Di Franco (2002) studied improvisation in psychodynamic music therapy with an 8-year-old client with a diagnosis of ASD. The study found that improvisation in music therapy can offer opportunities to reach clients with communication difficulties. For example, the music therapist created melodic patterns on the piano within which the client could improvise freely in the space provided (Di Franco, 2002). The findings suggest that within the relational context of improvisation between
client and music therapist, musical relationships can form and strengthen, and the communicative abilities of the client can be cultivated in the music (Di Franco, 2002).

Taken together, these studies demonstrate that improvisation is a valuable method of connecting with children with developmental delays and challenges, strengthening the therapeutic relationship, and improving communication between the client and music therapist.

Method

Participants

Following approval of this thesis study by the Institutional Review Board (IRB) at Molloy College, participants were recruited via email. Prospective participants were music therapists meeting the following inclusion criteria: 1) They utilized improvisational voicework in their music therapy practice; 2) They had a minimum of 5 years of experience working in a clinical setting; and 3) They were certified by the Certification Board for Music Therapists (CBMT). Participants were recruited through snowball sampling within the music therapy community. Snowball sampling can be defined as when “the researcher asks a research participant to put him or her in contact with similar people who might provide rich data” (Keith, 2016, p. 495). Each participant received a cover letter that outlined the purpose of the study, method of research, and protocols for protecting the rights of participants. Once the participants agreed to participate, they signed an informed consent form confirming their agreement to the terms of the study, as well as to the recording of their interview via Zoom.

The participants selected for this study were both board-certified music therapists who utilize the Nordoff-Robbins approach to music therapy. The participants were assigned the pseudonyms “Participant A” and “Participant B” to maintain anonymity. Participant A is an experienced music therapist working with children, adolescents, and adults with developmental
delays at a music therapy center in the Northeast United States. She utilizes improvisational voicework in her music therapy practice, though she does not consider her primary instrument to be voice. She is a frequent contributor to music therapy literature. Participant B is also a music therapist working with children, adolescents, and adults with developmental delays at a music therapy center in the Northeast United States. Though his primary instrument is not voice, he uses improvisational voicework in his music therapy practice. This participant was a previous supervisor of mine during my graduate studies.

**Design**

This study employed IPA to explore music therapists’ perception and experience of the client-therapist relationship in the context of vocal improvisation and voicework. I conducted semi-structured interviews inviting participants to share their subjective, lived experience of this phenomenon in their clinical work. Bruscia and Wheeler (2016) define a phenomenological study as examining “how a person feels, thinks, and derives meaning from a lived phenomenon, that is, something that a person has actually experienced” (p. 60).

Murray (2014) conducted a study similar to the present investigation, in which she explored the experience of music therapists with vocal health issues through a phenomenological design. She held semi-structured interviews with three music therapists examining their experiences and thoughts regarding working as a music therapist with vocal health issues. The data collected in the interviews were then analyzed to identify emergent themes. The present study followed a similar protocol for thematic exploration.

**Data Collection**

One semi-structured virtual interview, approximately 50 minutes in length, was conducted with each of the two participants through the Zoom video conferencing platform. The
interviews were recorded, with participants’ consent. The interview questions explored each participant’s experiences and perceptions of the client-music therapist relationship in connection with vocal improvisation and voicework. Narrative, contrast, descriptive, and structural questions were designed to guide the discussion, allowing the participants to explore their experiences and perceptions in an open-ended way (Smith et al., 2009). The interview questions included:

1. How would you describe the role of singing and voicework in your music therapy sessions?
2. How would you describe the nature of your therapeutic relationship with clients and its development over the course of therapy?
3. How would you describe your approach to clinical improvisation?
4. How do you experience your therapeutic relationship with clients during singing and vocal improvisation? Is this similar to or different from your experience of the therapeutic relationship during other types of musical interaction?
5. How would you compare the nature of your therapeutic relationship with clients in and out of music?

The participants were also encouraged to reference specific therapy sessions or share video clips of their clinical work, with their clients’ permission, to provide supplemental data supporting their narratives of their experience.

Data Analysis

Written transcriptions of each interview were prepared and sent to the participants to be checked for accuracy and completeness. I then analyzed the transcriptions using the protocol for IPA: 1) Reading and rereading the transcriptions to enter the participants’ world, 2) Initial noting while listening to the interviews and reading the transcriptions, 3) Development of emergent
themes that have arisen while noting, and 4) Searching for connections across emerging themes (Smith et al., 2009). I then explored connections among the themes in-depth to gain insight into the music therapists’ experience of the client-music therapist relationship in implementing improvisational voicework. The results of the study are presented through discussion of emergent themes along with selected direct quotations from the interview transcripts.

Data Protection

All email correspondence with participants occurred through my private academic email account. Interviews were conducted via Zoom, a secure, encrypted video conferencing platform. Interviews were scheduled at the participants’ convenience, at a time when both the participant and I could be situated in a private location that was not conducive to disturbance. All review of interview recordings took place in a private location. All interview recordings, interview transcripts, and materials generated during data analysis were securely stored on my personal computer using an encrypted password protection system, and will be maintained in this secure storage for at least 3 years following the completion of the study. I have sole access to this password-protected computer.

Participants are referred to anonymously using pseudonyms throughout the analysis and presentation of findings. Participants were informed that they could withdraw from the study at any time and for any reason without penalty and that they could choose to omit any question during the interview which they did not feel comfortable answering. They were asked to check the transcripts of their interviews to verify accuracy and were informed that they had the right to review the recordings of their interviews.
Trustworthiness

Trustworthiness involved carrying out the study in a manner that was both rigorous and humanistic. Through member checking, participants were collaboratively included in the research process, being given “an opportunity to provide feedback on the researcher’s interpretations of their views, feelings, and experiences” (Baker, 2016, p. 107). Trustworthiness was also achieved through triangulation, which can be defined as using “multiple methods of data collection to facilitate engagement with data on more than one level (Keith, 2016, p. 492). For this study, data were collected from a variety of sources, including the video recorded interviews, the written transcriptions of the interviews, and the participants’ feedback on the written transcriptions.

Additionally, trustworthiness was sought through my prolonged engagement with the data to “gain a deep understanding of the context, culture, and meaning” (Arnason, 2016, p. 853). To achieve this, I reviewed the video recordings of the interviews multiple times in preparing the written transcriptions and sent them to the participants to check and revise, if necessary, prior to conducting the analysis. Finally, confirmability was established through bracketing my perceptions and reactions when conducting interviews and analyzing data (Hiller, 2016). I sought to be optimally receptive and responsive to the participants’ perspectives by maintaining awareness of my own perceptions, experiences, and biases. This was especially important in that I had previously had a working relationship with one of the participants; he had been one of my supervisors during my training. I reflected on my prior experiences with this participant and our shared client, in an effort to ensure that I was mindful of the distinction between our past experiences and current discussion.
Results

Multiple themes arose that were common to both participants’ understanding of the role of the voice and vocal improvisation in the context of the therapeutic relationship. Both participants expressed the belief that the voice is an essential component of music therapy. They emphasized that in using the voice, the music therapist is the instrument, and that the use of the voice is both a vulnerable and an authentic way to connect with clients. Both participants maintained that confidence and comfort are essential in using the voice as a music therapist. They also reflected on the need for awareness of power dynamics that may arise while singing with others. The participants outlined specific cases in which they worked solely through voicework and vocal improvisation with clients; this led to enhanced expression for the client and enhanced communication between client and music therapist. Some of these gains generalized into the client’s everyday life. The participants also emphasized the idea that when all else fails, the voice is what we have left to work with in music therapy.

The Vulnerability of the Voice

A superordinate theme that emerged from both participants’ interview responses was The Vulnerability of the Voice. The participants described the voice as a personal aspect of ourselves that we share when we sing in sessions, allowing us to connect, communicate with, and relate to our clients. Two related subthemes were the following: 1) You Are the Instrument, and 2) The Need for Confidence and Comfort in Using the Voice as a Music Therapist.

You Are the Instrument

Participant A and B both described using the voice as an intimate experience that allows others to see us in a vulnerable way, which is different from the way we may be viewed during instrumental improvisation. Participant B stated that the voice
is the only instrument between the client and therapist that is us… There’s so much about the intimate part of [the voice] that’s who you are and what you sound like. We can change some things, but we can’t completely redo our voice.

Participant A characterized voicework as crucial to music therapy, stating that the voice is “our natural human expression…our own instrument… I can’t imagine doing music therapy without singing.” She emphasized that the voice is very personal in that it comes from within one’s own body. The voice also allows the music therapist to connect, communicate, and relate with clients.

Participant B similarly expressed that in using the voice, we are the instrument. He also commented that because the voice is intimate, it can be scary or intimidating to sing with others.

Both participants emphasized the vulnerability and the potential for personal connection in using the voice. Sharing a personal aspect of themselves “as the instrument” with their clients impacts the way they connect and relate to the clients, and therefore affects the therapeutic relationship and the trust that is developing between them.

The Need for Confidence and Comfort in Using the Voice as a Music Therapist

As reflected in the interview responses of both participants, confidence and comfort in using the voice are a crucial part of competence as a music therapist. Music therapists need to be able to express different emotions through the voice, use different timbres and vocal inflections in response to our clients, and confidently sing in a way that does not intimidate the client.

Participant A cited a session with a former client in which she intended to express anger through her voice in the context of musical improvisation. Upon listening back to the session, she realized that her voice did not sound angry at all, but was rather very quiet despite her singing. “I’m angry!” Participant A remarked that she was initially uncomfortable with singing
loudly and expressing this emotion. It was through working with this client that she became more comfortable using her voice expressively in different ways. She observed that

through our work together [with clients], you learn to become more comfortable with all aspects of yourself… As a music therapist, you need to be comfortable with your voice and expressing all different feelings, because that’s what we’re asking our clients to do.

Participant A commented that clients may experience self-consciousness, as well, in using their voice in sessions. She suggested that this may reflect fear of not singing the “right” thing, perhaps due to having been judged to be wrong in the past. She observed that sometimes clients will not sing unless they are completely sure and confident of what they are singing. She also suggested that clients may hold back in their singing until they are comfortable with the music therapist.

Participant B described his process of becoming comfortable with using his voice in music therapy sessions. As someone who does not consider himself to be primarily a vocalist, it took time for him to become comfortable with committing to using the voice as needed in sessions. Possibly due to his gradual process of developing comfort in using the voice, he described his approach to vocal improvisation in sessions as more intentional than intuitive.

Regarding his musical decisions in improvisation, Participant B stated:

I wonder how I may differ from someone who is a vocal primary, in that I feel that it took me a lot of time to develop a real comfort [in the voice]…to commit one hundred percent to using my voice whenever I feel that it is needed… When I was using [the voice] and do use it, I think there may be even more intentionality in its function… I’m choosing very specific timbres, I’m using dynamics… I think of the balance of intention versus intuition very much… I think I have a little bit more intention and less intuition in my
vocal responses…the intuition [comes] to me in other ways. It doesn’t come to me as often through the voice.

He characterized his use of the voice as more of a cognitive process, in comparison to his use of other mediums in music therapy sessions. He observed that he often makes a conscious effort not to appear too confident in singing during sessions (e.g., he might avoid using a “full-powered voice”) in order to avoid intimidating the client. In addition to making musical decisions with intention when using the voice, he approaches singing with clients in a way that is largely dependent on the client’s confidence in using their voice at that point in time.

Both participants asserted that the music therapist must be able to sing in different ways and with different qualities in order to express emotions or reflect and respond to the client in the music. In doing so, they are modeling the confidence and comfort in using the voice that they are hoping to nurture in their clients, in order to connect and communicate with them in the music.

**Intentionality in Singing and the “Creative Now”**

Both participants emphasized the importance of the “creative now” (Nordoff et al., 2007) in improvising with their clients. Regarding this concept, Markworth (2014) explains that “through creating music to meet the client in his or her current emotional state, a connection is made, and the music then has the potential to inspire change in the client” (p. 5). Within the superordinate theme of Intentionality in Singing and the “Creative Now,” there were two subthemes: 1) Singing as Communication and Expression, and 2) Roles and Dynamics in Singing. The participants observed that being intentional with what and how they play and sing in each moment can impact the response and music of the client, as well as the development of trust in the therapeutic relationship.

**Singing as Communication and Expression**
Participants A and B both cited cases in which singing provided a unique pathway of therapy for their clients. Singing became a means of communication with these clients, offering them possibilities of expression that they might not otherwise have had. Participant A described ways in which singing helped clients work through emotions and express themselves, and strengthened the therapeutic relationship between the client and music therapist. Participant B described a case in which singing helped him to communicate with his client through inter-responsive vocalization. Both participants spoke of the need to remain present in the moment and to work in the “creative now” (Nordoff et al., 2007) in order to authentically meet the client where they are musically and emotionally.

Participant A described her use of the voice to reflect the qualities of what her clients appear to be feeling or what they are doing during the session. She said that in sessions, she often tries “to pick up some aspect of their inner state or their feeling and put that into my voice so that I can reflect it back to them.” This may allow the client to feel heard and understood by someone in the outside world. She explained that she tries to pick up on the qualities of their voice or movements, some of which they may not be aware of, and place these within a musical context. In reflecting the clients’ movements, vocalizations, or emotions, she stated, “I want to help them make it [a vocalization, movement, emotion, etc.] more musical and transform it into something that’s more of a musical expression and not just this raw emotion.”

Participant A cited a case in which the voice played an essential role in the course of therapy for a young girl with developmental delays. The client expressed emotions in regard to her family, identity, and sense of belonging in the world through songs or arias that she created. Participant A would either vocalize in response to the client in a “musical conversation” or would listen and act as a witness to her singing and lyric creation. In reflecting on this case,
Participant A stated: “The voice became a means of dialogue for us, and we’d sing together and kind of enter each other’s experience.” Through the use of the voice and the dramatic play that accompanied it, she was able to support the client in working through emotions by means of vocal improvisation and lyric creation. Voicework became the client’s primary means of expression, processing emotions, and communication with the music therapist.

Participant B cited a case in which he used solely voicework to connect with a client who was otherwise challenging to reach due to his intense, pervasive sensory issues. Participant B observed in sessions that the client appeared to have no musical intent when offered instruments to play; however, he consistently vocalized. Participant B described the client’s voice as having unique qualities in timbre and phrasing. When Participant B reflected these vocalizations back to the client through instrumental improvisation, there was minimal response; however, once he began reflecting what he was hearing through his voice, the course of therapy changed.

Participant B stated:

I feel like our connection really happened when I started singing with him and being more comfortable…and through vocalizing together, [the voice] allowed us to connect in that way, because he would change his voice in response to mine… It was some of the first times that I knew that he could hear me… [Using the voice] was our only pathway to finding each other.

According to Participant B, these vocal exchanges became more meaningful and intentional as he began to understand how to connect with the client. He observed that through this pathway of musical engagement, the client then began to seek out other means of musical engagement (e.g., instrumental play).
For this client, vocal work became a significant therapeutic experience and appeared to impact the therapeutic relationship in a profound and meaningful way. Participant B reflected that before their work together, “I don’t think anyone knew how to answer him. To make it meaningful.” There is also evidence that their work together generalized into his communication skills in daily life: the client’s mother shared that she tried to communicate with him at home in a manner similar to the therapist’s communication with him in music therapy sessions.

In the cases cited by both Participants A and B, voicework played a crucial role in the development of the therapeutic relationship, through the clients’ enhanced ability to express themselves and communicate with the therapist.

**Roles and Dynamics in Singing**

The participants described various roles and dynamics within the process of vocal improvisation with clients, which influence and are influenced by the therapeutic relationship. Participant A observed that some clients may feel pressured to sing, or think the therapist has expectations of them in the music. Clients could also feel generally self-conscious with respect to singing and using the voice. Participant A explained that in her approach to using the voice in therapy, she will often leave space in the music in order to invite the client to sing with her. She stated, “If I’m going to sing all the time, they’re probably not going to sing, they’re going to listen… If you want somebody to sing, you have to leave them space to sing.” Participant A also noted, however, that music therapists must be careful not to leave too much space, because it could cause the client to feel pressured to sing. She recommended that music therapists maintain a balance between leaving space and providing structure in the music in order to encourage clients to sing.
Both participants noted that what and how you sing can impact the client’s response, as well as their confidence in their voice. Participant A gave the example of choosing intervals. If the music therapist sings a descending interval and ends on the tonic, it could appear to imply that the song has concluded. This could potentially discourage the client from singing in response, because the music already sounds complete.

As we have seen, both participants felt that music therapists must develop the confidence to use the voice flexibly and responsively in therapy. However, both also emphasized the need for awareness of the way that music therapists project their confidence when singing with clients. Participant B referred specifically to the “power dynamics” that can occur in vocal improvisation. He observed that there are certain roles that he plays in singing with his clients, such as lead singer, background singer, and harmonizer, depending on what the client needs in the moment. He stated:

I try to be sensitive to the power dynamics that may be unfolding… I can be supportive and at times use my voice, but it’ll be more selectively, in a way, almost like a background singer for them, providing context or answering things; occasionally, harmonizing.

He explained that he does not want to sing over a client unless it is relevant to the music that his voice should be at the forefront. Participant B remarked that if a client is not as confident in their voice, he may not want to sing in a way that exudes too much confidence, so as not to intimidate the client. Participant B stated that he pays close attention to the potential power dynamics between the “leader” and the “background singer” in vocal improvisation, carefully considering when to play each role with each specific client. He is especially mindful of these considerations with clients who are gradually building confidence in using their voices:
It’s like we’ve recently planted this seed for them and it’s starting to grow, but I try to be very careful about when I use a more supported, full-powered voice, like, expanding my own confidence, because I try to be conscious of the potential intimidation that that may bring.

Participant B pointed out the need for balance between trying not to intimidate the client, while also exuding confidence to let the client know that you are present with them in the moment.

**The Music Is Enough**

Another emergent superordinate theme, The Music Is Enough, contained two subthemes:

1) **Change Happens in the Music**, and 2) **The Voice Is What We Have Left**. Both participants expressed the view that therapeutic change happens within the music, through being with the client in the “creative now” (Nordoff et al., 2007) by listening, observing, and reflecting back what they express in the music. As discussed above, both participants regard the voice as a deeply personal means of connection, which allows the therapist and client to meet in the moment. They both cited cases in which the voice was their “last resort” which led to discovery of a pathway to connect and communicate in the music.

**Change Happens in the Music**

Participant A stated that using her voice in the “creative now” (Nordoff & Robbins, 2007) involves being highly alert while listening to and observing the client, and then responding in the music. While in the “creative now,” she is making clinical decisions based on where the client is in each moment. When asked if she noticed a difference in the therapeutic relationship in and out of music, Participant A stated, “I don’t see really the value of the words outside of music.” Describing the function and role of music in her music therapy work, she stated:
Generally, I try to keep as much in the music as I can, because that’s what we do that’s different from what everybody else does; it’s what we can offer that’s unique… It’s them coming into this space of the music room – we call it sacred space – because things happen there that are unique to their lives, hopefully.

Participant B explained that before a client enters the room, he meditates on who the client is, their past experiences together, and the music they have made together, in order to attain a focused awareness of the client, be present with them in the music, and be open to any changes that may happen in the music. He identified this frame of mind as the “creative now” (Nordoff et. al, 2007) and stated, “When it comes to actually being creative and working live, the ‘creative now’ is everything.”

The Voice Is What We Have Left

Participant A described her work with a 5-year-old boy with Autism Spectrum Disorder, in which the voice was the main medium for therapy. This client would often become aggressive and throw any instruments and furniture that were in the session room. Participant A eventually took everything out of the room, and the voice was all that they had left. She said that once everything had been removed from the room, the client lay on the floor and began to vocalize. In response, Participant A stated:

I would vocalize back, and then we developed this whole relationship of singing together because, sort of by default, I had taken everything else out; but that was what we had left.

And I think that’s true. That’s always what’s left, is the voice.

Here, the therapeutic relationship was established through the use of the voice: “When we were working just with the voice, all of a sudden we had a new way to connect.” Participant A stated
that through vocalizing, the client could channel his anger and aggression into the vocalizations and then was able to move to a different state of feeling.

Participant B described voicework as a “pathway” to musical connection in the case of the aforementioned client with developmental delays whom he was unable to reach through instrumental improvisation. When he met the client in the present moment and vocalized with him in a reflective way, Participant B was able to discern that the client was hearing him and responding to him in the unfolding of the vocal exchanges in the music. It was through vocalizing together that the client was able to communicate and relate to Participant B in the music. Since the use of instruments initially did not lead to intentional music-making by the client, the voice was what was left; and the voice became the pathway to communication between the client and Participant B. This pathway evidently allowed the client to begin to feel understood and to communicate in a meaningful way with Participant B, and eventually led the client to join in intentional instrument playing.

**Discussion**

The purpose of this study was to explore music therapists’ experience of the therapeutic relationship in using vocal improvisation. The interviews generated three superordinate themes that were composed of subthemes related to the responses of each participant. The superordinate themes included 1) The Vulnerability of the Voice, 2) Intentionality in Singing and the “Creative Now,” and 3) The Music Is Enough. The subthemes emphasized the personal aspect of using the voice in therapy, the confidence and comfort needed to use the voice as a music therapist, and the roles and dynamics that occur within the therapeutic relationship during vocal improvisation. Both participants described working in the “creative now” (Nordoff et al., 2007), and cited cases in which vocal improvisation provided a uniquely effective means of expression and
communication for their clients. The participants identified the voice as a “doorway” and “pathway” that could strengthen the therapeutic relationship over the course of therapy.

**Improvisational Voicework and the Therapeutic Relationship**

Both participants spoke of how vocal work impacts the therapeutic relationship and vice versa. They discussed the vocal confidence and comfort that is required of both the client and therapist. A parallel process may occur between the client and therapist as they develop confidence and comfort in singing and vocally improvising together. This parallel process, in which the client and therapist share a vulnerable and personal aspect of themselves with each other, could impact the therapeutic relationship by enhancing empathy and understanding between the client and therapist. Simultaneously, as the therapeutic relationship develops over time, trust develops, which may also lead the client to feel more inclined to sing.

Both participants explored the dynamics and roles that can emerge within the music as clients and therapists sing together, which influence and are influenced by the therapeutic relationship. Cole (2003) referred to musical interactions in music therapy as “musical meetings” and stated that “the relational moments…can be seen as therapeutic goals” (p. 87). Both Participants A and B felt that the music therapist would ideally create music that encourages the client to sing without causing the client to feel pressured to sing. Participant A emphasized the importance of singing in a way that provides this opportunity (e.g., avoiding intervals that end on the tonic, which would leave the musical phrase already sounding complete). She stated that clients may feel that there are expectations of them in the session, which may impact their responses in the music; hence, therapists must be aware of the sense of expectation that may be conveyed by the music. *What and how* one sings must be given attention in improvising with the
client, in order to provide a space for the client to improvise that is perceived as supportive and inviting, rather than intimidating.

Participant B described the possible vocal roles he may play with respect to a client, such as lead singer, backup singer, or harmonizer. In making clinical decisions as to which roles to play, Participant B remains present in the moment and meets the client where they are in regard to their confidence and comfort in their voice. The way the music therapist portrays themselves in the music may impact the musical responses of the client and thus impact the therapeutic relationship. If the client feels safe in the therapeutic relationship and has established trust with the music therapist, they may be more inclined to sing, or perhaps even take on more of a leadership role in the music.

Singing and voicework can provide opportunities for clients to express themselves, release emotions, and connect feelings to sound (Austin, 2009). The cases referenced by both participants in the interviews suggested that the voice can help build the therapeutic relationship, given that sometimes the voice and vocal improvisation are the only means by which music therapists can relate to and communicate with clients. Improvisation can provide clients the opportunity to explore their emotions in depth through music (Turry, 2007). The cases shared by the participants demonstrate the unfolding of the therapeutic relationship through improvisational exploration by client and therapist solely using the voice. The use of the voice was the way that the participants and their clients were initially able to relate to one another, and ultimately created the pathway for building the therapeutic relationship. Vocal improvisation allowed the participants to meet their clients in the present moment by remaining in the “creative now” (Nordoff et al., 2007), offering music that could support, empathize, and communicate with each client.
Austin states that “the process of finding one’s voice, one’s own sound, is a metaphor for finding one’s self” (2009, p. 21). The use of voicework in therapy was referred to by the participants as a “pathway” or “window” into each client’s world. This led to a new way for the client to connect and communicate with the therapist. Without the use of the voice in the specific cases cited, one might wonder how the course of therapy would have unfolded. Would the client have been reached or understood? Would the therapeutic relationship have developed and evolved?

**Active Engagement in the Research Process**

The interviews conducted in this study provided valuable insight into the voice and the therapeutic relationship through the unique lens of each participant. Having worked with Participant B as his supervisee in the past, the interview allowed me to gain a different perspective on his work and practice, while reflecting on his work that I have observed and taken part in. While working with him, I also worked with one of the clients whom he referenced in the interview, which gave me more insight into the context of the case and its relation to the themes that emerged from the interviews. In analyzing the data from his interview, I needed to acknowledge and remain aware of my firsthand perspective and thoughts on his work versus the information that he provided in the interview. The interview with Participant A was a more formal meeting, as we had only met once previously. While familiar with her work, I did not have personal experience working with her outside of this study. I had an outsider’s perspective on her interview and analyzed it based solely on her narrative of her experience of voicework and vocal improvisation in relation to the client-music therapist relationship.

**Limitations and Suggestions for Future Research**
This study explored music therapists’ experience of the therapeutic relationship in using improvisational voicework through the perspective of two Nordoff-Robbins music therapists. In analyzing the data, many parallels could be drawn between the perspectives of the two participants. A limitation of the study is the lack of diversity in the music therapists’ theoretical approach. The inclusion of music therapists who utilize different approaches within the field, such as Vocal Psychotherapy, Analytical Music Therapy, or Neurological Music Therapy, would provide more diverse perspectives and would portray the role of the voice in the therapeutic relationship in a more generalizable way. In addition, the data could be enriched by including participants who work in a variety of settings, such as psychiatric, hospital, or palliative care settings.

**Implications for the Field**

The findings of this study imply that the voice and vocal improvisation play an important role in music therapy with respect to the development of the therapeutic relationship. The use of the voice can enrich the therapeutic relationship by creating a pathway for communication between the client and music therapist that might not otherwise exist. It may also be a unique means of expression for the client. Further research is needed to explore the role of vocal improvisation and voicework in developing the therapeutic relationship across theoretical approaches and client populations.

**Conclusion**

Vocal improvisation and the use of the voice in music therapy, as illustrated by the interviews with participants in this study, are a powerful means of expression for clients and provide an opportunity for meaningful connection between the client and music therapist. Whether the client is vocalizing freely or creating lyrics to tell their story, vocal improvisation
allows them to be heard and understood by the music therapist. This study explored two music therapists’ perspectives on the therapeutic relationship in the context of improvisational voicework. The participants cited cases illustrating the importance of singing and vocal improvisation in music therapy. They emphasized that in using the voice, one *is* the instrument. Their experiences demonstrated that music therapists must be able to use their voices confidently and effectively in a variety of ways in order to be present with each client in the “creative now” (Nordoff et al., 2007). The voice is sometimes the only pathway to understanding and communicating with clients and building the therapeutic relationship. As stated by Participant A, “that’s always what’s left…the voice.”
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Music Therapy Commons.


Appendix A

Molloy College

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DATE: December 14, 2020

TO: Samantha Schick
FROM: Molloy College IRB

PROJECT TITLE: [1694918-1] The Music Therapist's Experience of the Client-Therapist Relationship in Improvisational Voicework

REFERENCE #: 
SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS
DECISION DATE: December 14, 2020

REVIEW CATEGORY: Exemption category # (2)

Thank you for your submission of New Project materials for this project. The Molloy College IRB has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations. However, exempt research activities are subject to the same human subject protections and ethical standards as outlined in the Belmont Report.

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

Though this protocol does not require annual IRB review, the IRB requires an annual report of your exempt protocol (Expedited and Exempt Research Protocol Annual Report Form) which is available on the IRB webpage.

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.

We will retain a copy of this correspondence within our records.

If you have any questions, please contact Patricia Eckardt at 516-323-3711 or peckardt@molloy.edu. Please include your project title and reference number in all correspondence with this committee.

Sincerely,

Patricia Eckardt, Ph.D., RN, FAAN
Chair, Molloy College Institutional Review Board
Appendix B

Letter to Prospective Participants

Dear ________________,

My name is Samantha Schick. I am a M.S. student in music therapy at Molloy College. I am writing to invite you to participate in my thesis study on music therapists’ experience of the client-therapist relationship in the context of improvisational voicework. My faculty sponsor is Dr. Maria ("Nina") Guerrero, PhD, MT-BC, Adjunct Instructor in the Graduate Music Therapy Program in the Music Department at Molloy College. This study will be a qualitative investigation exploring music therapists’ perceptions and experiences of the therapeutic relationship in the context of improvisational voicework with clients.

If you agree to participate in the study, you will be asked to take part in a semi-structured individual interview, approximately 60 minutes in length, conducted virtually through the Zoom teleconferencing platform. The privacy of the interview will be safeguarded through a unique link and password given to each participant. In the interviews, I will ask participants semi-structured, open-ended questions. If they choose, participants may also share brief video excerpts of therapy sessions, with their clients’ permission, to illustrate their clinical work and narrative of their experiences. Interviews will be conducted during the spring semester of 2021 and will be scheduled at participants’ convenience.

With participants’ consent, interviews will be video recorded through the Zoom platform. I will prepare a written transcription of each interview and will analyze the transcripts using the protocol outlined for an Interpretive Phenomenological Analysis. Participants will be asked to check my written transcription of their respective interviews to help ensure accuracy and completeness. Participants will have the right to review the video recording of their interview, as well as request that any portion of the recording be destroyed. By agreeing to participate in this study, participants agree to the recording, transcription, and thematic analysis of their interview.

All video recordings, transcripts, analysis of the interviews, and scans of consent forms, will be stored electronically on a password-protected hard drive, to which only I will have access. In addition, participant anonymity will be preserved through the use of pseudonyms throughout the transcription and analysis of interviews and presentation findings.

There are no known risks associated with your participation in this research beyond those of everyday life. Although this study will not provide you with specific direct benefits, it will offer an opportunity for exploration and discussion of the therapeutic relationship in the context of improvisational voicework. The findings of this research may contribute to enhanced understanding of therapy utilizing improvisational voicework with clients.

Participation in this study is voluntary. You may decline to participate in the study or withdraw at any time, for any reason, without penalty. To find out more about the study, please carefully read the attached informed consent form, and return the scan to me via email as a PDF document. If you have any questions or concerns about the study, you may contact me at...
sschick@lions.molloy.edu or my faculty sponsor Dr. Nina Guerrero at mguerrero@molloy.edu. Thank you for your consideration.

Sincerely,

Samantha Schick
Appendix C

Title of Study: The Music Therapist’s Experience of the Client-Therapist Relationship in Improvisational Voicework

This study is being conducted by:
Samantha Schick, MT-BC
sschick@lions.molloy.edu
Graduate Student

Maria C. “Nina” Guerrero, PhD, MT-BC
mguerrero@molloy.edu
Faculty Advisor

Key Information about this study:
This consent form is designed to inform you about the study you are being asked to participate in. Here you will find a brief summary about the study; however, you can find more detailed information later on in the form.

For this study, I will be interviewing two music therapists who use improvisational voicework in their music therapy practice. The purpose of this study is to explore music therapists’ perceptions and experience of the client-therapist relationship in the context of improvisational voicework. For data collection, I will conduct one semi-structured interview with each participant, approximately 60 minutes in length, through the Zoom video conferencing platform. The interviews will be video recorded with the informed consent of the participants. I will prepare a written transcription of each interview, which will be sent to the participants to check for accuracy and completeness. I will analyze the transcripts for themes related to the therapeutic relationship in the context of improvisational voicework. All recordings, transcripts, and analysis of the interviews will be secured in a password-protected computer utilizing an encrypted password-protection protocol. Participant anonymity will be maintained through the use of pseudonyms in the transcription and analysis of interviews and the presentation findings.
Why am I being asked to take part in this study?

The purpose of this study is to explore music therapists' perception and experience of the client-therapist relationship in the context of improvisational voicework. I am seeking to include board-certified music therapists who utilize improvisational voicework in their music therapy practice and have a minimum of five years of experience working in a clinical setting.

What will I be asked to do?

Participants will be asked to take part in one semi-structured interview via Zoom, in which they will discuss their experience and perception of the client-therapist relationship in the context of improvisational voicework. Participants may also choose to share video vignettes from their therapy sessions, with their clients' permission, to illustrate their clinical work. The interviews will be recorded, with the informed consent of the participants. Participants will be asked to check the written transcription of their respective interviews to ensure accuracy.

Where is the study going to take place, and how long will it take?

Participants will be asked to participate in one semi-structured virtual interview via Zoom, approximately 60 minutes in length, to be scheduled at the participants' convenience. Participants will also be asked to check the written transcription of their interview to ensure accuracy. This study will be conducted during the spring of 2021.

What are the risks and discomforts?

It is not possible to identify all potential risks in research; however, reasonable safeguards have been taken to minimize known risks. Despite the data protection and security protocols that will be put in place, the risk involved in this study would be a breach of the data protection plan that could result in the unauthorized release of data. Participants' anonymity will be protected through the use of pseudonyms in the collection and analysis of data.

What are the expected benefits of this research?

Although this study will not provide participants with specific direct benefits, it will offer an opportunity for the exploration and discussion of the therapeutic relationship in the context of improvisational voicework. The findings of this research may contribute to enhanced understanding of therapy utilizing improvisational voicework with clients.

Do I have to take part in this study?

Participation in this study is entirely voluntary. Participants may withdraw at any time throughout the study, and for any reason, without penalty.

What are the alternatives to being in this study?

Instead of being in this research, you may choose not to participate.

Who will have access to my information?

The researcher alone will have access to your information. Recordings, transcripts, and analysis of interviews, along with informed consent forms, will be securely stored on a password-protected hard drive to which the researcher will have sole access. Participants' anonymity will
be maintained through the use of pseudonyms throughout the transcription and analysis of interviews and the presentation of findings.

**How will my [information/biospecimens] be used?**
Data collected in this study will be analyzed by the researcher to explore music therapists' perceptions and experience of the client-therapist relationship in the context of improvisational voicework.

**To ensure that this research activity is being conducted properly, Molloy College's Institutional Review Board (IRB), whose members are responsible for the protection of human subjects' rights for all Molloy-approved research protocols, have the right to review study records, but confidentiality will be maintained as allowed by law.**

**Can my participation in the study end early?**
Participants can withdraw from the study at any time, for any reason, without penalty.

**Will I receive any compensation for participating in the study?**
No

**What if I have questions?**
Before you decide whether you’d like to participate in this study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact Samantha Schick at sschick@lions.molloy.edu or Maria C. “Nina” Guerrero, PhD, MT-BC (Faculty Advisor) at mguerrero@molloy.edu

**What are my rights as a research participant?**
You have rights as a research participant. All research with human participants is reviewed by a committee called the Institutional Review Board (IRB) which works to protect your rights and welfare.

If you have questions about your rights, an unresolved question, a concern or complaint about this research you may contact the IRB contact the Molloy IRB office at irb@molloy.edu or call 516 323 3000.

**Documentation of Informed Consent:**
You are freely making a decision whether to be in this research study. Signing this form means that
1. you have read and understood this consent form
2. you have had your questions answered, and
3. after sufficient time to make your choice, you have decided to be in the study.

You will be given a copy of this consent form to keep.
Participant also consents to the video recording of the interview conducted via Zoom teleconferencing platform:

Your signature  
Date

Your printed name  
Date

Signature of researcher explaining study  
Date

Printed name of researcher explaining study