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Musical and Verbal Interventions in Music Therapy: A Qualitative Study

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Introduction

In clinical work, our main task as music therapists is to make interventions: we give our clients guidance, encouragement, and support; we offer interpretations; we play with and for them. Most of the interventions are either musical or verbal. As a music therapy clinician, supervisor, and educator, I wanted to explore the following questions: (a) How do music therapists define musical and verbal interventions? (b) When does a music therapist intervene musically and when does the therapist intervene verbally? (c) When and why do music therapists suggest to their clients exploring an issue musically or verbally? (d) Do musical and verbal interventions serve the same purpose or different purposes? (d) How is the decision about the type of intervention made? and, (e) is there a difference between the power and meaning of musical interventions versus verbal interventions for both the therapist and the client?

Literature Review

Musical and Verbal Interventions in Music Therapy

In reviewing the music therapy literature, I was surprised to find that the word "intervention" does not appear as a topic in any of the books, chapters, and articles reviewed. I found a lot written about musical techniques, procedures, methods, and processes, and much less written about verbal methods and techniques. Bruscia (1987) differentiates between procedures and techniques. A procedure is "a strategy or method used by the therapist to engage the client in a specific aspect of the therapeutic process, or to accomplish a specific methodological objective. The method or strategy may consist

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of a series of operations or interactions, and may be accomplished through the use of various techniques" (p. 16). The purpose of a procedure is "to engage the client therapeutically. . . . Examples of procedures are improvisations, discussions of improvisations, projective story telling. Examples of techniques are musical reflection, movement synchrony and verbal confrontation" (p. 16).[1]

The literature also focuses on the place of music versus the place of words in music therapy. Until recently, there were three main perceptions:

1. Models that are based on the perception of "music as therapy": All interventions are musical and there is little talking during the session. If there is talking, it is not considered a psychotherapeutic intervention (Ansdell, 1995; Lee, 1992; Nordoff & Robbins, 1977, 1992; Robbins & Robbins in Bruscia, 1991).
2. Models that are based on the belief that music is the primary force of change but that verbal interventions are used in order to communicate ideas, share insights, make interpretations, and so on (Alvin, 1976, 1977, 1981, 1982; Bonny, 1978a, 1978b, 1980; Priestley, 1975, 1978, 1987, 1988, 1994).
3. Models that are based on the perception of "music in therapy" and give equal importance to musical and verbal interventions in music therapy (Katsh & Merle-Fishman in Bruscia, 1987; Platch, 1980, Rioedan-Bruscia in Bruscia, 1987; Sokolov in Bruscia, 1987; Stephans in Bruscia, 1987).

Questions concerning the use of music and words in music therapy are discussed within the context of the relationship of music therapy and psychotherapy. Recently, there has been an interesting exchange among "Nordoff-Robbins" practitioners. They debate whether or not "Creative Music Therapy" can be described and understood as a psychodynamic work. Some are convinced that this approach is purely musical and has no function outside the musi-

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[1] See Bruscia's taxonomy of 64 clinical techniques used in improvisational music therapy. The techniques are grouped under 9 headings according to their purpose in the session: techniques of empathy, structuring techniques, techniques of intimacy, elicitation techniques, redirection techniques, procedural techniques, emotional exploration techniques, referential techniques, and discussion techniques (1987, pp. 533–537).

cal realm (Ansdell, 1995). Others, including Clive Robbins himself, argue that this approach is indeed a psychodynamic approach (Aigen, 1995, 1998; Pavlicevic, 1997; Turry in Bruscia, 1998).[2] Lee (personal communication, 1998) feels that even though music is the fundamental channel for expression, there is also meaning outside the musical realm. Lee (1992) suggests that this meaning—the verbal evaluation—comes from a different source other than psychotherapy, and requires "its own model of processing" (p. 23).

Pavlicevic (1997), offering a different position, addresses the issue of the relationship between music therapy and psychotherapy and suggests the need "to separate the music therapy act from the way this act is understood, explained, described and portrayed—and theorised about" (p. 140). She sees the relationship between the act and its meaning from several perspectives:

1. This position defines the clinical work as purely musical, and lets the music 'speak for itself.' In this position, the therapist's understanding is that the music is the therapy. Therefore, words are not needed and might even interfere with the client-therapist relationship. This position can be clearly observed when working in clinical improvisation with nonverbal clients.
2. This position acknowledges that although the therapy happens in the music, through its clinical use, "its meaning is more than just musical" (p. 140). However, this meaning can 'look after itself,' and does not need to be delved into—and certainly not through words.
3. A third position includes therapists who base their understanding of the music therapy act on behavioral or cognitive meaning and use this language to describe what happens in the therapy process.
4. A fourth position is that music is therapeutic and there is no need to talk about it with the client, but the therapist needs to "absorb the full, complex, multi-faceted meaning of the event, which understanding will inform the therapeutic act, embodied through the jointly created improvisation" (p. 140).
5. A fifth position is that, in order to understand the musical event, we need to talk about it, and if we do not talk about it, the

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[2] See the April 1996 issue of the *Newsletter of the International Association of Nordoff-Robbins Music Therapists,* New York, Jacqueline Birnbaum, editor.

> experience remains incomplete and it will be impossible for the client to bring it into consciousness.

Pavlicevic argues that what determines the use of music and words—how, why, and when these are being used in music therapy—is whether these positions are being placed within the frame of psychodynamic thinking or not.

In "The Dynamics of Music Psychotherapy," Bruscia (1998) sheds light on the issues of transference and countertransference. In music psychotherapy, many of the therapist's interventions can and should be examined as countertransference reactions. Bruscia differentiates between intrasubjective countertransference—"all those issues that have been formed by the therapist independently, not on the basis of experiences with the client" (1998, p. 71), and intersubjective countertransference—all the issues that emerge in working with a particular client. Some of the signs of the latter include: unwarranted or inexplicable reactions, impulsive decision-making, drastic changes in the use of music, and inappropriate roles and relationships (71–91).

As mentioned above, verbal intervention in music therapy appears to receive little attention in the literature. If we look at Bruscia's taxonomy, we can clearly see that most of the headings include pure musical techniques. Bruscia's verbal techniques can be regrouped into four categories: verbal techniques that come after an improvisation (such as reacting, analogizing, and reporting); verbal techniques that are being used before improvisations (such as enabling and experimenting); verbal techniques that are being used during an improvisation (such as pausing and story-telling); and discussion techniques—verbal techniques that are separate from the improvisation (Bruscia, 1987).

Wolfe, O'Connell, and Epps (1998) analyzed the therapist's verbalizations during group music therapy. The purpose of the research was to "systematically observe, categorize and quantify the kinds of verbalizations that the music therapist employed" during a series of group music therapy sessions with music therapy graduate and undergraduate students that were conducted for the purpose of the investigation (p. 13). Two studies were conducted: Study I attempted to define and place verbal interventions into general verbal categories. Three general categories were established: (a) Continuing responses—interventions used in order to encourage clients to continue talking; (b) Leading responses—influencing/re-

inforcing, advice giving, and using questions or statements in order to gather more information; and (c) Others—instructions, explanations, self-disclosure, opening and closing remarks.

Study II examined only the verbal interventions having to do with music. Major categories of therapist's verbalizations included: (a) music instructions, (b) musical explanations, (c) paraphrasing/clarifying, (d) personal reactions/observations, (e) questions/directives, and (f) reinforcement.

The researchers found that the therapist focused mainly on eliciting verbalizations from group members concerning the music and in reflecting and clarifying the members' responses. Also, the researchers emphasized that verbally supporting group members for their participation in the music activity and in the discussion also seemed to be a vital component of group music therapy. One of their recommendations was to conduct further research, both qualitative and quantitative, in order to deepen the knowledge and understanding of different kinds of verbal interventions used by the therapist in group music therapy.

I could not find specific literature that deals with basic considerations of the use of intervention in music therapy, such as the timing of interventions, indications for interventions, and special considerations in intervening. Therefore, I turned into the literature on psychotherapy.

Interventions in Verbal Psychotherapy

Among the many psychotherapists who have written about interventions are Adler and Buie (1972), Adler and Meyerson (1973), Blos (1972), Greenson (1967), Langs (1973–74), and Wolberg (1977). Langs (1973–4) devotes a whole chapter in his book *The techniques of psychoanalytic psychotherapy* to the therapist's interventions. Naturally, most of the interventions are verbal interventions such as questions and clarifications, confrontations, interpretations, reconstructions and supportive interventions. The first intervention technique that Langs introduces, however, is silence. He emphasizes the importance of silence and listening to the patient, and explains silence as constructive nonverbal communication. Langs also talks about basic considerations in intervening. The timing of interventions, indications for interventions, the style and level of the intervention, special and nonverbal considerations in intervening, positive, negative and painful nonverbal implications of interventions

and nonverbal characteristics of interventions are crucial in gaining an integrated understanding of the therapeutic process: when and how to intervene and when not to do so (pp. 599–628).

Qualitative Research Method

A qualitative method of data gathering and data analysis was utilized in order to gain an insight into musical and verbal interventions. Colaizzi (1978) talks about a "dialogical interview" for the purpose of "imaginative listening": the researcher interviews the participant about the experience she is interested in studying and is able to extract the content as well as nonverbal cues (p. 62).

Two models of qualitative analysis served as a basis for this research: Colaizzi's first phenomenological method—"protocol analysis" (1978) and Ely's model (Ely, Anzul, Friedman, Garner, & McCormanck Steinmetz, 1991). "Protocol analysis" is when the researcher gathers descriptions of experiences and analyzes them through several steps: making "protocols"—written transcriptions, which become the data source; reading all the protocols and starting to become familiar with them; and, extracting significant statements from the protocols. "These are phrases or sentences pertaining directly to the phenomenon under investigation" (Forinash, in Wheeler, 1995, p. 373–374); formulating meanings—trying to understand what the participant talks about in the significant statements and revealing its meaning; this is done with all the protocols. As the formulated meanings begin to overlap they are organized into clusters of themes which are then validated by a return to the original protocol; the results are integrated into an exhaustive description of the topic being studied; formulating the description in "as unequivocal a statement of identification of its fundamental structure as possible" (Colaizzi, 1978, p. 61); the results are given to the research participants and validated by them, and that is integrated back into the final product.

Ely et al. (1991) see qualitative data analysis as a thorough examination of all the raw data in an effort to establish meaning. "The product of analysis is a creation that speaks to the heart of what was learned" (p. 140). It is important to say that the analysis of the data is a process that begins with the first interview, and goes hand in hand with the gathering of the data. "This process of analysis guides the researcher to focus and refocus observational and/or interview lenses, to phrase and rephrase research question, to es-

TABLE 1

Information About Research Participants

Training and Experience	Main Psychological Orientations	Main Music Therapy Orientations	Types of Populations
USA (4) Europe (1) Israel (1)	Psychoanalytic, Humanistic, Transpersonal, Developmental, Holistic	Analytical MT—Mary Priestley; Creative MT—Nordoff-Robbins; GIM—Helen Bonny	Normal neurotic adults, Psychiatric adults, Music therapy students, Autistic children, Children with Rett's Syndrome, Mentally retarded children, Emotionally disturbed & hospitalized psychotic adolescents, Adolescents with PDD

tablish and check emergent hunches, trends, insights, ideas, to face oneself as research instrument" (p. 140). Ely's model consists of the discovery of core categories and themes. A core category is one that relates to as many categories and subcategories as possible and is central to the integration of the findings; a theme is a statement of meaning that runs through all or most of the data or one in the minority that carries meaningful impact (Ely, 1984).

Research Method

Data Collection and Data Analysis

This study seeks to illuminate and understand issues concerning musical and verbal interventions. Six experienced music therapists in Israel and the USA were interviewed (see Table 1).

Data analysis. Two models—Ely et al. (1991) and Colaizzi (1978), as well as my previous study on meaningful moments in the music therapy experience (Amir, 1990, 1993) served as a framework for the actual process of the data analysis. The actual analysis consisted of nine steps:

1. Conducting interviews: At the beginning of the interview, I told each participant the topic of the study and presented them with

a series of questions about the experience being studied (see *Introduction*). Interviews were open ended. Participants were asked to give a general statement about the subject and then to give examples from their work.

2. All interviews were audiotaped and transcribed verbatim. After I finished transcribing each interview I added comments about my own feelings, thoughts, and impressions throughout the interview.
3. Making protocols: I started to become familiar with the content of each interview through listening to the tapes and reading the transcribed material, and I created an initial organization of data in categories for each interview.
4. Building categories: I read the protocols and came up with further lists of categories.
5. Reshaping and refining the categories: I started to organize each protocol in core and subcategories.
6. Discovering themes: I found statements of meaning that represent amalgams of statements made by interviewees.
7. The protocols were given to another researcher, who performed steps 3–5. After comparing notes, the protocols were reorganized.
8. All protocols were sent to the participants to read and to make corrections and comments. Comments were integrated into the final protocol.
9. Second level analysis: cross analysis of all the protocols. Results were integrated into an exhaustive description of the topic being studied. The reorganized and interpreted data into a set of core and subcategories and clusters of themes were validated by returning to the original protocol.

Trustworthiness of the study. In order to assure credibility, I used several techniques:

1. Peer debriefing—"It is a process of exposing oneself to a peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (Lincoln & Guba, 1985, p. 308). All protocols were given to a second researcher who read them and made comments.
2. Intensive contact with the phenomenon under study. I feel that I achieved a close contact with the phenomenon under study

through my becoming thoroughly familiar with the content of the interviews. I did this by repeated listening to the tapes and reading the transcriptions and the process notes.

3. Member checks—a process "whereby data, analytic categories, interpretations and conclusions are tested with members of those stakeholding groups from whom the data were originally collected" (Lincoln & Guba, 1985, p. 314). All protocols were sent to the participants to read and to make corrections and comments. The comments were integrated into the final product.

Research Findings

Findings were organized in eight core-categories: (a) definitions of musical and verbal interventions, (b) general functions of musical and verbal interventions, (c) factors that influence the therapist in making decisions concerning interventions, (d) transitions from one mode to the other, (e) musical and verbal interventions: types and techniques, (f) meaning of instruments in musical interventions, (g) decision making process, and (h) therapist's role.

Since it is beyond the scope of this article to present all the findings, only the first four core-categories will be presented. The findings are presented in three ways:

1. A descriptive summary of definitions of musical and verbal interventions.
2. Themes (printed in bold) along with quotes that exemplify the themes (see steps 6, 9 in the process of data analysis). The themes represent my analysis. Most of them are written in my own words, while a few are participants' verbatim statements. The purpose of the quotes is to bring the participants' exact words so that the reader can understand where my analysis stems from.
3. Lists of points that summarize core categories b–d (see step 9 in the process of data analysis).

Definitions of Interventions in Music Therapy

An intervention in music therapy is any initiative that I, the therapist, take within the therapeutic setting for the purpose of helping my client to move on. These interventions are mainly verbal and musical suggestions and actions. They come in various types and serve different purposes. They are the end product of com-

plicated inner processes of decision-making. I, the therapist, have thoughts, perceptions, feelings, sensations about my client. I listen to them, analyze them, interpret them, focus on something specific, give it priority—"this is what is important to say or to do" and express it at the right time, based on my immediate understanding and on my therapeutic assumptions. These suggestions and actions are based on a conscious decision that an intervention would be appropriate at that time. They are done intentionally, purposefully, intuitively, or cognitively, according to the level, type, and stage of therapy, to the client population, clients' cognitive and verbal ability, client's needs and issues, the meaning of music for the client, purpose of treatment, and according to the therapist's musicality, knowledge, experience, theoretical orientation and belief system.

Definition of musical intervention. Musical intervention is an action by me, the therapist, coming out in a musical expression for the purpose of making a change in my client's inner being through changes in the music (the focus and direction of the music, the dynamic between the two players). Changes in my client's music are made either dynamically, harmonically, tonally, or rhythmically. I choose the musical intervention in a moment to moment flow of the session. It comes out intuitively and spontaneously from my inner music. It has intention and purpose, but it is not always known beforehand. The interventions come mainly in the form of songwriting, improvisation, and the use of recorded music.

Definition of verbal interventions. Verbal intervention in music therapy has two basic meanings:

1. It is a psychotherapeutic technique, an intended suggestion by me, the therapist, coming out in a verbal expression for the purpose of working on something with my client. It is done mainly with verbal "normal neurotic" adult clients, where the level of therapy is reeducative and reconstructive. Usually the verbal intervention is a tentative presentation of an idea to be played with, or rejected.
2. It is an invitation to use musical means. It is geared towards a nonverbal experience with an inner understanding of why I am doing it. It has intention and purpose. I invite my client to play, and I consider this invitation an intervention. The arts therapies not only allow this kind of intervention but require it.

Themes

The themes (I–XV) are organized according to six general questions.

Question 1: Musical versus *verbal interventions or musical* and *verbal interventions?*

I Verbal and musical interventions complement each other: one route is not the only road, and it's not a better road than the other, just different.

> We are complex and very vast human beings. I can work things and get insights through the music and I can work things and get insights through words.
>
> I don't like to distinguish between verbal and musical interventions, they are two different types of interventions that both accomplish something important.

II The relationship is the bigger picture. When I am working with somebody for a long time, the flow between music and words doesn't feel that different.

> Words and music can be secondary to the overall relationship: it is all part of me relating to another person. The overriding considerations with some clients is how do they relate to me; how does their relationship to me change, so I just wanted to say that, because we can get caught up in the words doing something, the music doing something and not really look at the bigger picture which is about relationship.
>
> Through relationship we get to know each other better and to accept each other more fully, so really what's happening in our relationship is that we have gotten to learn to know each other and a big thing for him is to accept me for all my mistakes.

Question 2: Why do I use music in my interventions?

III I believe in music. Music has unique therapeutic power: it is nonverbal and goes beyond words.

III-A There is something about music that is more revealing than words. It is easier to tap well protected emotions with music. One can hide in words, it is more difficult to hide in music.

If I did it through the music, he could allow himself to experience himself in a more full way than if I were to just say it with words. It's his will, it is his soul will, sensitivities, his healthy ego function, his cognitive organization that hasn't been touched by his pathology. When he plays music, he feels whole, joy and pure . . . he feels confident, because he feels competent.

III-B Music taps all levels and dimensions in the human psyche: it taps into the cognitive, mental, physical, emotional and spiritual dimensions; it is an experience that has to do not only with the conscious but also with the unconscious.

Music is as wide as the client's emotional experiences are. Music has a rich emotional component—the emotional tone of the melody, the richness and the complexities of the harmonies is something that the client can relate to because he has had emotional experiences in his life but he cannot consciously communicate them or become aware of them but he knows it to be true.

III-C Two sounds can be played by the therapist at the same time. Therefore, musical interventions can be made on several levels simultaneously.

(S. gives an example of) a 27 year-old Korean woman client, who came to NY, feels very lonely and isolated and has an eating disorder. B describes her intervention in one session: . . . I took the cello and I made sounds on the cello that mirrored different sounds: One sound realm was very soothing: long deep tones on the deep string, and the (other one was) underneath the bridge—there are very short strings and when you play those it squeaks like an ill child screaming (she demonstrates a high and very soft eeeeeeeeee tone). Here I played both the mother that was supporting and holding the crying child and mirroring the little child who was crying.

III-D When I play for my client, I can give her the message that she does not have to do all the work by herself—I, the therapist, can actively assist her. I can give her a present. I can give something from myself that is more than just words. My playing for her can ease her way to play, can make it less dangerous for her to take the risk.

(S. gives an example of a Korean client with eating disorders): when she came in for the first session she told me that she was very scared of playing and she probably won't play any of the instruments or use her voice for the first half year and I said fine, and after we talked for a while I said to her would you mind if I play for you sometimes and she said no and then what happened in the end after she had been talking about self-hatred and also very depressed feelings and feelings of being very lonely she started crying and then I chose to ask her how would it be for you if I accompany your tears and she said that will be OK. I felt that it was important to give her the impression that it can be undangerous to play, and you don't have to play aesthetically, you know that it doesn't have to sound beautiful . . . So that was a way for me—a message to give to her nonverbally that it's OK. I think that it also gave her permission to play, to dare, to get courage.

III-E I can play with my client simultaneously: sometimes, the sound can get very big and it is hard not to hear it.

The actual, physical sound can be so big that you cannot run away from it. you cannot defend yourself from it, and it can bring an instant understanding and transformation.

(In playing the dream of a client who was suicidal, S. explains that) this image of the abused dog became so clear through the musical sound image that he got very shocked and he actually stopped having suicidal thoughts.

III-F Music is a preverbal medium. It has to do with processes, has to do with a less defended place within ourselves. Therefore, my musical interventions can allow for experiences that are connected with very early childhood.

Music and sound is one of the first things that we experience as infants in and out of the embryo . . . In early childhood the baby needs to be held by his parents. Music as used by the therapist can satisfy this need.

III-G Music is unknown. Therefore, it allows for surprise, spontaneity and for the discovery of new ways of being and understanding. At the same time, music is known and familiar. There-

fore, it allows for a feeling of safety and security, for freedom and organization.

The construction of the music: the logic of the melodic intervals, the phrasing, the organization of the tones itself, is something that he can tap into and organize his own thinking.

IV I use music because this is my role as a music therapist—this is what I am here to do.

Most of the treatment should be in music as much as possible. On a personal level, I feel that what I have to offer has to do with music. What I bring to therapy as a therapist has a lot to do with my musical self.

I am a strong believer in the power of music and its therapeutic potential. Therefore, I try to use mostly music.

I try to approach the whole session as musical. Even when I am talking—there is timing involved, a sense of pacing—the same elements that have to do with music.

V I use music because this is the mode that I feel most comfortable with.

I am a strong believer in music and I am good at it. I have been most deeply touched by music.

I know my musical self very well. My musical strength influences my decisions.

I feel less comfortable when it comes to verbal interventions; when I am talking, I try to figure out what to say. It feels more intellectual, more rational. It is an effort. When I need to do a verbal intervention, I can feel the switch that is required within me, it is not smooth. I was never trained as a verbal therapist.

I will always feel in a more natural state playing music. It can make me feel like I am sharing a much deeper part of myself.

I have to do more thinking than I like to do when it comes to verbal interventions.

V-A In my musical interventions, I use instruments I feel most comfortable with.

I feel most comfortable using my voice and singing. It is easier for me to express myself through my voice.

I prefer the guitar over the piano. I am not a great improviser on the piano. I come from a classical piano background and let's say that I have a lot to improve on piano improvisation.

I feel completely at home, like a fish in the water with piano skills, piano improvisations, and piano interventions.

Question 3: Why do I use words in my interventions?

VI Through words, I get to learn what are the client's concepts and ideas and how does the client think about things.

VII Words must be used in order to acknowledge the experience and bring it from the unconscious to the conscious.

With psychotic adolescents, it is very important to talk about what happened in the music, because not to talk about it is to let them stay on an unconscious level. The goal is to bring it to their conscious level. Not to talk about it is almost to say that it didn't happen.

VIII When I get confused, words help me clarify what is going on in the music.

Question 4: What influences me in making interventions?

IX My theoretical orientation, perceptions and meanings I attach to music and words.

IX-A-1 Musical experiences can be interpreted: I can hear things in my client's music that I connect to my client's traumatic life events. There is music that represents my client's pathology and there is music that represent my client's healthy place.

When a client plays music, I hear things that might come from the unconscious, things that are coming from a child place in them, a historic place in them.

. . . even though my client was 27, I experienced that she presented much younger child or a much younger person. I experienced as she was sitting and crying a very little girl very lonely and very unhappy.

IX-A-2 Musical experiences can be interpreted. However, I do not interpret my clients' experience in the music and imagery. They find the meaning themselves.

If a person sees a butterfly in one (GIM) session, and the butterfly does something, next session they might see the butterfly differently. The more they get to see the butterfly in its different aspects, the more they understand the image.

IX-B Musical experiences cannot be interpreted. The music speaks for itself.

Music has to do with aesthetic and beauty and cannot be described in words. Every attempt to do that will ruin the experience.

IX-C Music can access a healthy–potentially healthy part of the self and thus allows the client to work on pathology, conflicts, stuck places, problematic areas and give the client hope.

The client's music is completely free. It isn't highly structured, yet structured enough to give a sense of boundaries and security. There is contact between the patient and his music, congruence between patient's body language, his affect and his music explanation.

P. gives an example of a 14 year-old boy who has Tourette's syndrome and is psychotic. He exhibits bizarre behaviors in every setting: goes around spitting etc. He is very defensive, has a fragile personality, doesn't talk to anyone, feels that he is being attacked by everyone. In music therapy, he plays the piano and writes songs on the piano and on the guitar. He took the free improvisation like he has been doing it all his life, he has never done it until he got to the hospital, it is literally like throwing a fish in the water and I can do anything he can even do synchronization with me. He plays the same notes at the same time, and not only rhythmically, he can anticipate where I am going to go

melodically. [In his music] he doesn't have to be defended. He feels secure, completely safe. He knows where he is, he is grounded. He doesn't feel that he is being attacked. He keeps his psychosis out of the music.

IX-D Music can also be an expression of patient's pathology. Due to its power, music can touch deep, unconscious painful inner place that sometimes cannot be contained by the patient. The music can stimulates unreal, disturbed fantasies on how to deal with the pain that cannot be contained. In this case, music can be dangerous.

There is no congruence between patient's body, verbal, and musical language. It seems as if the patient is possessed by the music. The music controls the patient. Musical expression comes out of a very deep unconscious place, that is filled with murder rage that cannot be controlled, and deep crying that cannot be contained and is followed by a suicide attempt.

(P. gives an example of) a 17 year-old girl who has been hospitalized for over a year. She was physically abused by her father from the time she was a very little girl and on a daily basis. She was hospitalized after a suicide attempt. Her musical expression was filled with profound emotions. Her drumming and piano playing were a reproduction of being beaten. Her vocal improvisation opened within her the damaged, wounded inner child—her music said that she was crying deeply. She became acutely aware in the music of the need to kill herself. After the session, she would run to the kitchen and try to kill herself.

X My own experiences with words and music influence my interventions.

X-A My experiences in my own life.

X-A-1 I am a verbal human being, and therefore I need to talk to my clients, no matter how verbal they are.

It is important to talk to clients even if they are not able to talk back or to understand. Those two things must go together certainly with clients who are able to intellectualize and verbalize, but also with clients who don't talk.

Clients that are not verbalizing because they are not able to, I improvise most of the time but I do talk to the people after a musical communication, even though I know that they won't be able for some reason to talk back to me.

X-A-2 The more I am touched by music, good at it, experienced in making music and knowledgeable about it, the more music I use in my interventions.

I have been most deeply touched by music. I feel completely at home, like a fish in the water with musical skills, musical improvisations, and musical interventions.

I will always feel in a more natural state playing music. It can make me feel like I am sharing a much deeper part of myself. I know my musical self very well. My musical strength influences my decisions. I try to approach the whole session as musical. Even when I am talking—there is timing involved, a sense of pacing—the same elements that have to do with music.

X-B My experiences as a client in music and verbal psychotherapy.
X-B-1 From all the therapies I have been in music therapy has been the most effective in experiencing and learning about myself.

In the music I often see things about myself that I wasn't aware of—feelings, ways of being. The music and the music therapist provided me with a most meaningful experience that I didn't have in my childhood: I was being taken care of in the music.

In one of my music therapy sessions I had a transformative experience during the music: all of a sudden I understood something that I never understood like this before, and I didn't need to talk about that.

I went for individual music therapy . . . and for me as a person who is able to use words to defend myself very well and to run away from my feelings and even if I had understood some things in my head it is not really understood on a deeper level.

X-B-2 Verbal therapy has been most effective in working through my issues.

Talking with others often helps me to get insights about myself When I get confused, I need the words to help me clarify.

XI A lot has to do with my client's age and population.

XI-A The younger, the more handicapped and the more musical my client is, the more music I use in my interventions, and vice versa.

With severely disturbed, retarded, and handicapped children most of the work is in music. These children might not be aware of the therapist as a person but they may be aware of the music. They are highly motivated by music and as a therapist one needs to make use of it.

For the clients who are verbal it is important to verbalize around the music, the improvisations that you are making together because that is an integration of what you have experienced in the music and of your cognitive experience . . . those two things must go together in those cases where people are able to intellectualize and verbalize.

For clients who are psychotic or handicapped and have a layer of different problems, but a strength for them is their musical sensitivities, musical interventions can be more powerful than verbal interventions, no matter how verbal they are, or how old they are.

Music can be very powerful to the very musical clients. Music gives meaning to their lives. It gives evidence to their lives. It is something very profound for them.

With nonverbal children, you should use words through a musical mode—songs. It is much more powerful. The music puts the words in a context that is much bigger. It helps them to understand better.

XII A lot of it has to do with what are my (and my client's) therapeutic goals.

(In GIM), if I have a person who doesn't know how to image and how to use the sensory functions, and claims that he is always rationalizing and intellectualizing, I am not going to talk very much

in therapy; I am going to bring them more and more experience in the imagery realm. If I get someone who is wounded because he is flowing around in the imagery level and doesn't use their rational thinking mind, I may do more verbal processing

XIII Sometimes my interventions are based on my countertransference.

XIII-A They have to do more with my own issues than with my client's.

Am I playing because I need to play? Am I playing because I want to feel like a great musician? Am I playing because I want to prove that music therapy works?

On an inner-emotional level, I have a lot of similarities to him—I think we live in a similar emotional world in some ways. My relationship to certain music with certain emotional character are similar to his.

XIII-B They are reflections of my client's issues.

For a long time I heard in my client music repeated monotony . . . After a while I suddenly played on the harmonica clusters in a very loud dynamic and I felt bored and started to become very angry and expressed that on the accordion . . . To the supervision group it sounded as if I was abusing the client musically and it could be interjection of the client's mother or father or whatever had happened to him and that was important to find out.

XIII-C I can use my countertransference as a constructive or destructive clinical tool in my interventions. It can help me learn more about my client and my own inner being. It can also distance me and make me more cautious in getting involved and taking risks.

I have to take the risk of putting myself into the musical interaction. My musical interventions have to be real, genuine, alive—otherwise it won't work.

I have certain inner experiences concerning the client: I see images, pictures, have associations, remember something about the client.

I feel that countertransference is a term that can be used to distance oneself from the client . . . and the whole idea that somebody is holding back in the music because they don't want to get involved is not legitimate.

Question 5: How do I improve my interventions?

XIV I need to check my interventions in order to use them for the benefit of my client.
XIV-A I have to look at my own process and understand my reactions.

My clients are my teachers. I learn about myself, I learn more about what I can do with my client.

I was curious to find out what my musical expression was about because I didn't need to get angry or upset or be bored. I usually would empathize with a person . . . and I usually won't break in like that, so I went to my supervision group and played that episode . . .

XIV-B I have to learn more about my clients.
XIV-B-1 I need to know my client's history and to be aware of my client's needs.

I also understood the need of holding as she just moved to NY and had no other friends then a few Korean friends and missed her family, missed her boyfriend and I would say culturally isolated also. So, I asked her afterwards how did that feel for you (therapist played for client) and she said it felt like a relief and didn't feel so lonely for her.

XIV-B-2 I need to know what personal meanings the client gives to certain musical pieces, images, and instruments; I need to know what music helps the client to feel specific feelings and to deal with specific issues. I learn to know my client's musical expressions and ways of being.

. . . the flute for this client was beauty, love, God. The bassoon represented her former husband for her.

. . . I asked him also a little bit about his mother and his father. . . . So, we talked about the music . . . and I then asked him if it could

be that I took upon the behavior of his mother unconsciously . . . and then he said that it kind of made sense. . . . So, this clarified the dynamic that it was important for that person to change.

XIV-B-3 I learn to know how the client experiences my interventions and how he reacts to the things I say or do.

Through time, you learn this is what somebody might experience (my musical intervention) as mirroring, this is what somebody might experience as intrusive.

In playing together, he told me when he feels that I am too involved in the music; when I am being too intrusive, not giving him enough space in the music, when my mirroring feels to him like I am chasing him. At the same time, playing together has been a catharsis, emotional release, a sense of being understood, of not being alone.

Many times he said to me: you talk too much, you don't leave me room.

XIV-C I need to make an assessment of the situation: is this the right timing?

(My client can be in) a place that may not be appropriate at that time to deal with these issues, so it is obvious that I will not deal with it verbally.

There are clients who need holding, experience, mirroring, empathic reflection. These clients aren't ready for interpretation and a deeper understanding.

Question 6: How do I deal with transitions from one mode to another during a session?

XV Transitions are difficult to make.
XV-A It is an effort to move from the verbal mode into the musical mode; it requires a shift in energy.

In certain moments, the talking becomes meaningless, and it is hard for me to stop it and to go back to the music. I am not quite

sure when and how to do it. Sometimes my sense of timing gets off, I overstep.

I have to do more thinking than I like to do when it comes to verbal interventions.

It is an energy shift that sometimes calls for an effort. It has to do with changing position, getting to another frame of mind, to leave the familiar and let go.

XV-B It is hard to move from the musical mode to the verbal mode as well; it is complicated, unnatural, never smooth.

I feel that I stop the flow of the experience and go into another realm of the experience.

Many times it is hard to leave the emotion being expressed and to move to the realm of words, analysis, understanding.

XV-B-1 It is especially hard when the music is beautiful.

If there has been a magical experience in the music, I feel embarrassed to go to the words: I am afraid of spoiling the experience; I am afraid of what might happen if someone needs to describe the beautiful sounds, because it cannot be described.

Sometimes, when I am enchanted with the music and I feel so drawn to it, I don't succeed in making the transition. It gets me connected to the "musician" within me, and I and my client are two people who play beautiful music together.

XV-C It is easier for me to make the transition with children than with adults.

Children are more flexible, they talk, they play, it is not a big shift for them.

There is a big difference between working with children and working with adults. For children, playing is a natural thing. They don't need an invitation to play. In general, they are more open to new experiences, more spontaneous in their use of the

room. For adults it is more natural to talk. The spontaneous, playing place within them has to be awakened, there is not much use of it. Many times they might need an invitation to use musical means.

Lists of Points that Summarize Each Category

General functions of musical interventions:

- to open a potential, creative space within the client—to enable an experience of play
- to check an issue in a fresh, less biased way
- to get out of the known, familiar, reserved place and dive into the unknown
- to have an experience, sometimes without understanding and clarity of what is going on
- to allow for a surprise, discovery, something new to take place
- to make an interpretation
- to increase client's level of energy
- to make a more intimate connection between client and therapist
- to stimulate and encourage motivation

General functions of verbal interventions:

- to open a space for understanding, awareness and clarity within the client's rational, cognitive mind
- to check issues that deal with content, descriptions and analyses
- to get to the known, natural and familiar mode of communication
- to take a distance, to be less involved, so that one can look at the experience from a different angle
- to make an interpretation
- to bring clients back from the unconscious to the conscious, from fantasy world to reality, from altered state of consciousness to regular consciousness.
- to acknowledge and give meaning to the experience: sometimes, not to talk about it is to almost say that it didn't happen.

Factors that influence the therapist in making decisions concerning interventions:

1. Therapist's theoretical orientation, perceptions, and meanings attached to music and words:
   - music can be interpreted
   - music cannot be interpreted
2. Therapist's own experiences with words and music:
   - in life
   - in her own therapy
   - as a professional
3. Therapist's knowledge of client:
   - client's age
   - client's population
   - client's needs
   - client's responses to specific interventions
   - therapist's and client's goals
4. Therapist's professional knowledge of therapeutic process:
   - level and depth of treatment
   - stage of therapy
   - kind of therapy (individual or group MT, GIM)
5. Therapist's countertransference issues
   - interventions that are influenced by therapist's own issues
   - interventions that are influenced by client's issues
6. Therapist's belief in music and its therapeutic power
7. Therapist's belief that it is her role to use music
8. Therapist's musical ability
9. Therapist's training in verbal psychotherapy

Transitions from one mode to the other during a session:

1. When does the therapist move from the musical realm to make a verbal intervention?
   - when the client gets so wrapped up with the music and avoids the message of the words (in a song)
   - when the therapist gets an insight and wants to share it with the client
   - when the client ends the musical experience
   - when the therapist feels that the client goes to dangerous places in the music
   - when the therapist feels that the client hides in the music and the improvisation doesn't go anywhere

2. When does the therapist move from the verbal realm to make a musical intervention?
   - when the client's words become redundant and meaningless
   - when the client uses words as a defense and makes a lot of intellectual judgments
   - when words are pulling away from the real issues
   - when talking about the experience distances the client from the experience and pulls him away from owning it, feeling that he really did it and accepting it
   - when talking becomes a way of avoiding getting involved, taking action, taking risks and explore
3. Ways to deal with transitions:
   - silence eases the way to go from music to words
   - the therapist goes ahead and "just do it"
   - the cognitive part takes over
   - one part of the therapist stays with the magical experience and another part takes over and does the verbalizing
   - it does not always work

Discussion

Overall, musical and verbal interventions make up the music therapy process. These are two different modes of experience and communication that complete each other. Both are important. One can see it as a dance between music and words (see Table 2). Some music therapy sessions are all music, some can be all verbal. some interventions are by nature a mixture of music and words that come together and cannot be separated (song writing, GIM, teaching a client how to play, etc.). Most verbal interventions in music therapy have a direct connection to the music: they come before, during, and after the musical experience.

Definitions of Interventions

An interesting question that came out from the study is: can everything that is played by the therapist be considered an intervention? Most therapists felt that the therapist's musical responses to client's specific requests are not interventions (for example, the client asks the therapist to accompany him in a song he wrote and wants to sing and the therapist plays exactly what the client asks her

TABLE 2

Similarities and Differences between Musical and Verbal Interventions

Musical Interventions	Verbal Interventions
Touch inner creative space, feelings, sensations, emotions, imagery Encourage musical insight	Create space for understanding, awareness, insight, clarity
Allow experiencing, playing (sometimes without clarity)	Allow the use of rational mind: reporting, describing, analyzing, interpreting
Increase energy	Clarifying, acknowledging
Mainly intuitive (sometimes cognitive)	Mainly cognitive (sometimes intuitive)
Multilevel and multidimensional: Playing separately—independence, exploration of intrapersonal world Playing together—interpersonal relationship, exploring issues of intimacy	Linear—one word at a time One person at a time—allow for clarity and careful listening
Allow to be totally involved in the here and now—it is hard to run away from it	Allow to take a distance It is easier to run away from it
It is unknown: Allow for discovery, surprise Can be unsafe, frightening It is known and familiar: allow for safety and security	It is known and familiar: Allow for safety, security Can be redundant, can get stuck, does not go anywhere (for verbal people)

to play). Let me argue that this can be true only theoretically. It would be impossible for the therapist to act in any way without it being interventive to some extent. The way the therapist plays influences the client (in the example above, the therapist accompanies her client's singing, and while doing it she intervenes by manipulating the musical elements according to the client's issues).

We might say that although musical interventions that have to do with improvised material have intention and purpose, these are not always known beforehand. When using musical interventions that have to do with known musical material, it is more likely that intention and purpose are known beforehand.

The same question came out with regard to verbal interventions: can everything we, therapists, say in a session be considered a verbal intervention? Some therapists felt that only those times when the therapist works verbally on client's issues can be considered as

verbal interventions. Others felt that verbal interventions in music therapy also included giving directions and suggestions on how to play. Most therapists agreed that certain things that are said by the therapist cannot be considered as interventions (saying hello and good bye to a client). However, if these things are being sung by the therapist, the song is approached as an intervention: it is purposeful, it has intention, it can be either a planned action (a song that you sing to your client every session) or an intuitive action (you improvise a song in order to get your client's attention). Only one therapist felt that everything which is being said by the therapist can and should be considered an intervention.

It is my belief that this issue should be further explored, both in supervision and in written material. It would interesting to understand the conscious and unconscious motives concerning this matter of what actions, musical and verbal, therapists consider as interventions and why.

Factors That Influence the Therapist in Making Decisions Concerning Interventions

In order to come to a better understanding of why musical and verbal interventions are being used, I would like to suggest three levels of therapist's awareness:

1. Factors that the therapist is very aware of, both in general and during the session. These are the times that some of the factors seem to be obvious and easily acknowledged by the therapist. For example, in the category of client's age and population: the therapist is very aware that the client is nonverbal and therefore she (the therapist) is only using music in the session. Another example: in the category of therapist's theoretical orientation and perceptions of music therapy: the therapist interprets the client's music because she believes that this is her task.
2. Factors that are less obvious but can be easily acknowledged by the therapist in her own exploration of the session (listening to the recorded session, viewing the session via videotape, reflecting after the session in writing up the session). For example: while listening to the recorded session, the therapist finds out that she did not use a verbal interpretation because she was unsure of what words to use and how to present the interpretation to her client.

3. Countertransferential factors that are not at all obvious and need to be explored through in-depth supervision. These are the therapist's unconscious reactions that are stimulated by her own issues or by her client's issues during therapy (see *Theme XIII*).

Transitions from One Mode to the Other

Even though it is fairly clear to the therapist when to move from one mode to the other, the actual task of making this change has proven to be a very delicate and difficult one. One reason for this is the very different nature of music versus words, something that requires a shift in energy, going from the emotional-musical realm into the realm of words, analysis, and understanding. Another reason for the difficulty is the countertransferential factors that are activated in making this move. A good example is a situation such as when the therapist does not succeed in making the move from the musical mode into the realm of words. This happens especially if the music is beautiful, and the therapist is enchanted with the music. This can be an interesting point concerning musical countertransference: the therapist intervenes musically based on her need to stay within the musical realm or based on her difficulty to leave the beautiful music. Unconsciously or partly consciously, the therapist stimulates and feeds the client's music without thinking at that moment if this is the right intervention at that time for that client.

One of the ways to deal with transitions is silence. Silence is a constructive nonverbal communication (Langs, 1973–74). In music therapy, the importance of silence is (a) to give room and honor the sounds that filled up the room (after an improvisation) and let them penetrate, and (b) to listen to our inner beings: to let ourselves and our client breathe.

Research Method

The utilization of several methods of qualitative analysis allowed me to explore known and observable aspects as well as covert and unobservable processes which occurred in relation to this phenomenon including me, the researcher. During the process of data gathering and data analysis I had to be aware of my bias with regard to the topic and be careful not to let it interfere with the findings. For example: The original topic of my research was: musical interventions *versus* verbal interventions in music therapy.

During the first stages of the analysis, I became aware that it was very important for me *to prove* that musical interventions are more meaningful and powerful than verbal interventions, and my analysis was too subjective in this sense. When I realized that, I had to go over the data again and again and look at it in a more objective manner. Only then could I see that each kind of intervention has its own unique meaning and power. One is not more important than the other, but different. The topic, therefore, was changed to: musical interventions *and* verbal interventions in music therapy.

Another dilemma was how to present the findings in a clear and organized manner; how to find the balance between presenting sufficient raw data and my own analysis (categories and themes). I think that this is a common dilemma that qualitative researchers share and it needs to be further discussed.

Summary

Interventions in music therapy have proven to be a vast, complex, and fascinating subject to research. In this study, I explored how six music therapists experience, apprehend, perceive, feel, and think about musical and verbal interventions.

It is my recommendation that many aspects of this phenomenon need to be given much attention in all realms of the profession: clinical practice, supervision, and training programs. The further we explore these issues, the better our clinical work will be. The research shows our need to grow, both personally and professionally, in order to improve our work. We need to carefully explore why and when are we doing what. We must, however, also honor the unknown qualities of our work and acknowledge the fact that some aspects will always be mysterious and should remain like that if we want to make the process a productive and beneficial one for the client. Seeking only cognitive knowledge can prevent us from taking risks and trusting our intuition. Searching for total wisdom can help us trust and understand our interventions, sometimes only intuitively. In this regard, I would like to conclude this article with the actual words of one of the therapists interviewed:

> "I allow myself to 'not know,' to make mistakes, to learn. I never know that my interventions are right. Sometimes they are right, sometimes they are wrong and sometimes they are proven to be unimportant."

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