

Voice and the Self in Improvised Music Therapy

Tina Warnock

Abstract

This essay examines the close relationship between the development of the self and the human voice, with reference to key theorists such as Jung, Winnicott and Stern. The focus is on an exploration of how these theories can be combined with our knowledge of the early vocal communication systems in the mother-infant dyad as a means of enhancing the quality of our voice work in music therapy practice. Music therapy and related literature in this area will be summarised, and the need for detailed studies in a wider range of clinical settings will be highlighted. Case examples will enable exploration of the application of these psychological concepts in work with children and young people with learning disabilities and autism, showing examples of shifts and developments which were seen to be direct results of working with the voice.

Keywords: Voice, self, music therapy

Introduction

*'To be born means to become sounding,
to have a voice means to be something which
has its own growth, its own development'*
(Streich 2009)

The inspiration for this essay originated eleven years ago, during my training. My experiences of personal development through singing had been highly influential in bringing me into the music therapy profession and the connection between the voice and the self has remained an important area of interest ever since. Since then, I have had opportunities through long term cases to reflect upon and observe how therapeutic processes are inextricably linked to the voice in my work.

Regardless of background or training, musicians and music therapists have some degree of emotional connection with their spoken and singing voice. This influences how we approach the use of our own and our client's voices¹ in

¹ In this essay the term 'voice' refers to the vocal sound in its non-verbal form, including timbre, pitch and volume, whether spontaneously uttered or deliberately sung

music therapy sessions. Some feel more secure using the instruments, while others will use the voice as central tool in the work. The same could be said for our clients who each bring their own historic relationship with their voice. The combination of both the therapist's and the client's vocal histories form the foundation of their vocal explorations in the sessions.

The interrelationship between the voice and the self is not a new concept, and most psychological theories mention the connection between the two. The intricacies and non-verbal vocal interactions of the mother-infant relationship are at the core of music therapy training. In this essay I will consider these processes within a range of music therapy settings, from the perspective of the client's

stage in self-development and level of verbal communication. Before this, a range of literature is introduced.

An overview of theories focusing on the Voice and the Self

This section of the essay provides a spread of theoretical stances that cover the area of the voice and the self. It is structured in six sections, each covering a different aspect of the literature.

a) The development of the self, and how it relates to language

Jung suggested that every human being is born with an existing self and describes this as 'an inner guiding factor that is different from the conscious personality...that brings about a constant extension and maturing of the personality...it may emerge slightly or it may develop relatively completely' (Jung 1964: 163) There are various opinions about when awareness of the self begins to unfold, and whether language *reveals* pre-existing senses of self or *creates* them so that they only exist when reflected upon.

Mahler's theory of Separation-Individuation suggested that a newborn infant experiences a symbiotic phase in which he cannot distinguish between himself and his mother, until the process of differentiation begins at around six months (Mahler 1975). In contrast, Stern stated that there are several senses of self, some of which already exist at birth. He described the self as a unique subjective organisation which appears in many forms, some of which reside beyond awareness, and, 'like breathing...they can be brought into and held in consciousness...Language and self-reflection could act simply by *revealing* senses of the self that already existed in the preverbal infant' (Stern, 1985: 5-6). Stern argued that the development of language and self-reflection first reveals these senses and then transforms them into new experiences. He proposed a model of the self based on four stages: the emergent self, the core self, the subjective self and the verbal self (Stern 1985). Each new sense of self builds on the previous one and continues to grow over time. Stern described the development of language as a 'double-edged sword', because as well as dramatically increasing our potential for thought and 'being with' another, it also makes some parts of our experience less sharable (Stern 1985: 162). He stated that 'global non-verbal experience...may be fractured or simply poorly misrepresented by the acquisition of language (Stern 1985: 175)

Winnicott emphasised the importance of supported play and creativity in the formation of the 'true self' and the concept of the 'transitional object', which an infant uses to discover his own creativity, was central to his theory and took a

more prominent place than the development of language². He suggested that when an infant's unintegrated state is reflected back by the mother it, 'becomes part of the organized individual personality ...and eventually enables [the infant]...to postulate the existence of the self' (Winnicott 1971: 86). He also stressed that the mother's responses to the infant need to originate from her own 'true self' for the child to be able to form his own.(Winnicott 1960, 1971)

These concepts form the basis of my thinking about the self for this article. I suggest that a sense of self exists before the development of language and can unfold without it, and that pre-verbal relationships and methods of communication play a vital role in setting the secure foundations for the awareness of this self, upon which a verbal awareness may or may not be built.

b) The voice and identity

As well as a 'self' we are also born with our own unique vocal timbre. From the beginning this voice becomes intricately entwined with our sense of identity, is continually affected by our thoughts and feelings (Bunt 1994) and 'reveals much about who we are' (Austin 1999: 143). An individual's emotional response to life experience can affect the qualities of their voice (for example tight, monotonous, warm, airy or piercing) and the experienced listener can make subsequent interpretations of some aspects of their psychological state. It is these kinds of vocal qualities that others identify with, thus affecting the way we are treated by others and in turn how we feel about ourselves. In addition, in-built vocal qualities cause their own associations within the person. Hence qualities in the voice can be heard and perceived as both a symptom and a cause of our emotional state. (Newham 1998: 24-25, Austin 2008: 13-14, 20)

Since parts of the self may be concealed, projected or misrepresented through the voice, it follows that work on the voice (with potential for discovering aspects that have been under-used, mis-used, lost or possibly yet to be found) might be helpful in encountering parts of the self and working towards a greater sense of integration. This is an area that has been explored and practised in various therapeutic disciplines.

c) The spoken voice in therapy sessions

Quinodoz wrote of the significance of the timbre and tone of the therapist's and client's voice in psychoanalysis, and the meanings found in non-verbal aspects of communication. There is acknowledgement of the importance of bodily awareness in developing self-awareness, and how this connects to and with the voice. She also stressed how the therapist needs a good understanding and awareness of unconscious processes, particularly where clients have difficulty symbolising and primarily use non-verbal means of communication. (Quinodoz 2003)

Austin wrote about the value of recording vocal psychotherapy sessions, and noticed a range of qualities within her and her client's verbal interactions, such as hearing judgement and impatience in her own voice, which enabled her to become aware of 'significant countertransference feelings' in her client, such as repressed anger (Austin 2008: 33). She noted the importance of

² The 'true self' is a sense of being alive and real in one's mind and body, having feelings that are spontaneous and unforced (Winnicott 1960). A 'transitional object' is one that is not part of the infant's body, nor fully recognised as belonging to external reality (Winnicott 1971: 3).

differentiating what feelings are her own versus those being projected into her by the client (Austin 2008).

d) Sound and healing

Vocal techniques have long been used for healing purposes in many cultures across the globe. An example is *vocal toning*, described by Austin as 'the conscious use of sustained vocal sounds for the purpose of restoring the body's balance. Sound vibrations free blocked energy and resonate with specific areas of the body to relieve emotional and physical stress and tension' (Austin, 2008: 29). Meditation and yoga approaches also use the voice to facilitate the healthy flow of physical and mental energy. We may learn from investigating these 'alternative' methods, which provide us with useful information to draw upon when thinking about the voice and the self.

e) The influence of disability or illness on the voice

Difficulties with vocal expression due to physical or mental illness, or disability influence the quality of life for those affected. Sinason's theory of 'secondary handicap' suggested that our presentation in the world induces people to treat us in certain ways which may then further amplify our difficulties (Sinason 1992). When a person is unable or unwilling to vocalise, or to say words clearly, we might make assumptions about what they can and cannot do and perhaps more significantly, what they do and do not want. This can limit their opportunities to make choices and lead to feelings of powerlessness and low self-esteem. This highlights the potential value of voice work with this client group - increased vocal strength and flexibility can lead to a greater sense of control and a stronger sense of identity.

With reference to Stern's thoughts about some aspects of communication being lost when language develops (see section a) I have wondered how this relates to people who are not able to speak. It seems possible that their non-verbal voice may retain the emotional openness present in the voice of a pre-verbal toddler, regardless of their age and emotional intelligence. Perhaps the conscious emotional connection to the non-verbal voice becomes latent once symbolic thought and language develops, thus making it harder to access? Working with non-verbal clients I have felt something meaningful in our vocal exchanges which I have not managed to capture in vocal work with verbal clients. I have also found that children who *can* speak are frequently resistant to the sound of their own singing voice, as if they are disconnected or afraid of it and prefer to sing songs with words that they already know.

This leads to another question regarding non-verbal clients: does a lack of verbal ability mean that they cannot develop a capacity for self-reflection? I would suggest not, and in support of the significance of non-verbal communication in self-development, I advocate both Stern's and Winnicott's emphasis on 'empathy and attunement rather than interpretation and insight as the curative factors in successful treatment' (Holmes 1995: 12).

Specific conditions such as autism have their own complex psychological interplay with the voice and the self. While often capable of using their voices and/or speaking words some autistic people are mute, perhaps due to a lack of motivation to use their voice, or a sense of detachment in which they do not recognise their voice as their own. Some may make frequent and repetitive vocal sounds which function like a barrier against the world³.

f) *The significance of pre-verbal vocal communication between mother and infant*

Mothers and infants communicate intimately and directly. They know one another yet they have no words (Pavlicevic 1997) and the voice is an important part of this communication system. From or before birth the mother will have been talking or singing to her baby, surrounding it with the sound of her voice as a way of showing that she is available and attentive to his/her needs. The maternal voice has been described as a 'bath of sound' or a 'sonorous envelope which surrounds, sustains and cherishes the child' (Taylor, as quoted in Newham 1998: 125). The mother's voice acts as a container, an acoustic space in which the child can feel safe, a concept linked with Bion's *container* that involves all aspects of the mother's presence, of which the voice is one (Shuttleworth 1989).

The mother's voice can be experienced as both nurturing and suffocating and felt to be 'over-present or not present enough', depending on the state of mind of the individual (Newham 1998: 126-7). These ambivalent feelings are thought to remain throughout life. Different qualities of voice provide different forms of containment and the nature of the container has a direct influence on the formation of the infant's identity (Newham 1998).

Therefore the voice provides a large part of the 'holding' environment the baby needs in order to develop an authentic sense of self and a means of connecting with others. Most mothers are able to provide this containment by allowing their instinctive emotional responses to guide them, and music therapists should nurture their ability to do the same, as via training. This is the underpinning of work for many music therapists, and although there are a number of publications that relate to the topic of the voice in music therapy, these tend to favour specific stances or approaches to work. This material will now be reviewed.

A Review of Music Therapy Literature about the Voice

Experience has shown that the majority of music therapy clients have difficulties with verbal articulation for physical, cognitive or emotional reasons, whether or not vocal issues are noted in referral. Considering the important part that the voice plays for both client and therapist in the therapy room, little literature covers this area.

As mentioned previously, Austin has published a record of considerable clinical experience in this area. In a recent publication, the importance of awareness of countertransference in the therapeutic process was emphasised, along with how Austin's vocal identity has had a significant impact on her work (Austin 2008). She described her vocal holding techniques which mirror mother-infant vocal interactions, create a sense of security and containment and provide

³ Although there is not the space to explore this further here, it is touched upon in subsequent case material.

an 'opportunity for a creative regression in the service of the self' (Austin 1999: 145). There are also examples of the importance of verbal interpretation in bringing meaning to the vocal interactions between Austin and her clients.

Heal shared her use of vocal improvisation with a teenage girl (Susan) with moderate learning difficulties, a very limited vocabulary and who was an elective mute at school. The therapist used her voice in a way that it was interchangeable with the keyboard. She found that by improvising with pre-verbal methods of turn-taking, imitation and initiation, she was able to address issues of control that Susan had not been able to process during her early childhood (Heal 1989).

Oldfield provided useful summaries of theories of early interaction and how they relate to music therapy practice, including the use of the voice (Oldfield 2006: 68-72). Oldfield also described how singing can be valuable in helping to 'improve or restore relationships between children and parents in a family' (Oldfield 1993: 46). A mother's singing helps to soothe and comfort her in her caring role; the relief it brings to the baby's stress boosts her confidence and sense of well-being enabling their relationship to grow (Oldfield 1993).

Magee and Davidson (2004) detailed how the voice provides a means of monitoring subtle physiological changes which have occurred due to the disease process in neurological patients. They also examined the emotional experience of singing songs of personal meaning for clients in therapy. Schneck and Berger (2005) investigated the links between music and physiological aspects of behaviour which they linked to subconscious fears and anxiety. An example of this was when humming and singing were used to help to slow the body rhythms of a boy with Aspergers syndrome who could not slow down or stop talking for fear that 'something dreadful' would happen. Long term music therapy enabled the reduction of his fears and contributed to an improvement in his concentration and sleep patterns.

Finally, this year saw the publication of 'Voicework in Music Therapy', documenting a wide range of projects focusing on vocal work in music therapy across the globe. The authors, both of whom have published a significant body of work on the subject, acknowledged that while discussion of the significance of the human voice in music therapy 'has only just begun....various individuals and communities throughout the centuries have long recognised the strong connection between the voice and the self' (Baker & Uhlig 2011: 25). Theory behind voicework in music therapy is explained, linking it with the growth of self-awareness and identity, thus contributing further to our understanding of this subject.

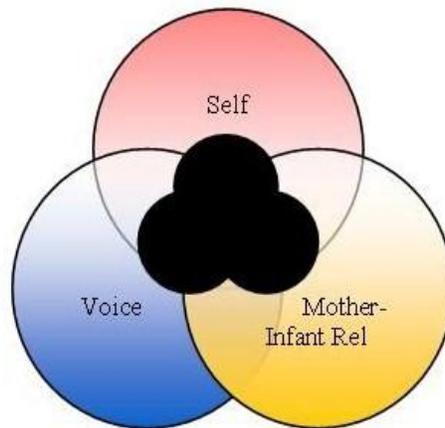
Therefore, a small but significant group of music therapists have written about the impact of voicework in music therapy, showing signs that the momentum to develop our thinking in this area is growing. Austin remains at the forefront of this field, and while verbal processing is clearly important for Austin's verbal clients in vocal psychotherapy, I suggest that verbal interpretation is not essential for vocal work to bring about change, and that the sounding of the voice itself carries its own intrinsic meaning for the client. I would like to focus now on considering how we might combine our knowledge of the theories and examples cited above with our awareness of vocal processes within ourselves,

and our skills as music therapists to enhance our use of voicework in music therapy.

The use of the Voice in Improvisational Music Therapy

Music therapists make use of sound and silence in order to help the client become more aware of themselves and of the way they relate to the world. As noted previously, the voice is present from birth and plays a central role in this vital stage of early development. It is also closely linked to the infant's sense of self and underpins a later sense of identity which is an area of main concern in most therapeutic environments. I suggest that a stance of attention to the voice in music therapy is of great benefit to the client, as illustrated in Figure 1.

Figure 1: *Diagram to show the connection between the self, the voice and the mother-baby (therapeutic) relationship*



Tina Warnock (2000)

This diagram illustrates how the mother-baby relationship is strongly linked to both the development of the self and to the voice. The three circles represent three parts of the client or patient – the 'self' (including their body), the voice, and the early relationship with the mother. The voice is connected to the sense of self, which is connected to the quality of interaction with the mother, which is in turn linked with the development of the voice. The mother-baby relationship in this model is compared to the therapeutic relationship (based on the assumption that early patterns of behaviour are re-played within this) and the solid shape in the centre represents the space where a music therapist can draw upon their experience and knowledge to bring the three together. This solid shape replicates the shape of the full model to remind us that the therapist too must be aware of these connections within themselves. This process presumes the inclusion of musical tools and techniques which replicate pre-verbal modes of interaction, and an understanding of theories of the self.

The overlapping areas between the circles link to the quality of the client's interpersonal relating, and reveal opportunities for intervention to the therapist. For example, if the client has a limited sense of self but a free voice, the

therapist can work with the voice to increase self-awareness. If the client has a restricted voice but a more developed self-awareness, the therapist can help further develop the voice. If both voice and self-awareness are limited, the therapist can use their knowledge of pre-verbal communication techniques and psychodynamic thinking in order to work towards those goals.

This model can be applied to clients of all ages and abilities and adapted to all stages of self development, vocal connection and quality of therapeutic relationship. Throughout a session therapists make choices about how much or little to use their voices, as well as maintaining awareness of which parts of the client's voice and other types of communication they respond to, along with the extent to which they use words.

Three clinical examples of use of the voice in Music Therapy

The following three case examples demonstrate how the above model has facilitated my understanding of voice work within my music therapy sessions.

1) An extended clinical example of vocal development as a manifestation of the Individuation process

This example covers work with a four year-old client over a five year period. Jolie⁴ was referred by the head teacher of a school for children with severe learning disabilities, autism and complex needs. Due to Jolie's emotional isolation and because of significant pressures at home, the school felt that she should be prioritised as a requiring extra support, including therapy. One central reason for a music therapy referral was that she spent much of her time vocalising to herself, yet she had no words. Eye contact was rare and she spent the majority of her time rocking back and forth and seeking sensory stimulation.

In the early sessions, Jolie and I both sat on the floor, cross legged. As I faced her she turned away, avoiding eye contact, rocking and vocalising repetitive three or four note motifs. My predominant memory of these sessions was one of 'being with' Jolie; gently seeking the transitional space that allows us to support young or delicate egos (Winnicott 1971). I thought of what Winnicott described as 'primary maternal preoccupation' and an environment which would nurture her 'True Self' (Winnicott 1960). I did not sense that Jolie's gestures were spontaneous and although tuneful, her voice was flat in timbre, repetitive and felt empty of meaning. I also felt empty and lacking connection, and experienced myself as struggling with a sense of insignificance and ineffectiveness. It was helpful to think about this form of countertransference in supervision, in relation to Jolie's autism and her experience of emotional detachment from her surroundings. Jolie seemed to be highly egocentric and her experiences were sensory and unintegrated, suggesting her awareness was similar to that of a newborn baby between 0 and 2 months old, matching Stern's 'Emergent Self' (Stern 1985). This thinking, combined with my belief in the therapeutic process and knowledge of the principles of mother/infant interaction enabled me to focus on using my own voice as kind of a container that 'surrounds, sustains and cherishes the child' (Newham 1998). I aimed to offer Jolie empathy and attunement in the belief that this would lead to new

⁴ The client's name has been changed to preserve anonymity/

connections with her voice and her self. Jolie and I continued to meet and for the next few months I often observed how she looked tired and distant, frequently looking at the floor or through rather than at people. She never smiled and it seemed that she did not have a concept of interaction, or of a world of separate individuals who had the potential to bring her into a shared space.

However, after around six months Jolie's sounds started to become more tuneful and varied. I felt the beginnings of a meaningful relationship and that she valued our time together. It is difficult to identify what brought about that change in atmosphere but it could have been a shift in her self-awareness, towards a 'Core Self' in which she could sense herself as a coherent body with control over her actions with me as an accompaniment (Stern 1985: 4-5). This affected the timbre and emotional quality of her voice and allowed her to take direct, deliberate glimpses at my face. We can see how our attachment was growing, but this was alongside my growing belly which was signalling the forthcoming break in our relationship for one year, when I took maternity leave. Although I did my best to prepare Jolie for this break by singing words about the sessions ending, and using a visual chart to count down the sessions, it was difficult to know how much she perceived about my pregnancy and the ending. I knew that she would be continuing music therapy with a locum music therapist and was hopeful that her growing self-awareness (the new life within her) would continue to grow and mature.

On my return it was heartening to hear how Jolie had found the sessions with the locum therapist meaningful and enjoyable, evidence for which could be seen in how she was generally livelier and more interested in the world. There was still little eye contact but one could observe energy, interest and curiosity in her eyes, rather like a baby who is able to focus on objects several meters away and perceive themselves in the context of their surroundings. Jolie enjoyed vocalising frequently with tuneful motifs that seemed to demand musical context. It was now possible to work via call and response techniques in the therapy, where Jolie would sing some notes and leave a space which I would fill by mirroring or developing her themes. I also sang words about what she was doing, or about the music being made, feeling that our time together was valued by her.

My role was still supportive rather than interactive until a breakthrough session a few months later. On this occasion Jolie sang one of her repetitive 3-note upward rhythmic motifs (a high C-D-E). The first two times she sang I repeated her notes exactly by picking out her motif on a guitar. The third time she repeated her sounds I sang a downward motif on different notes. To my surprise she copied my lower pitched notes exactly, placing them in time and on the beat. After repeating my motif a second time, I reflected my surprise vocally by singing a long high note, which she also repeated, looking at me whilst doing so. Suddenly we were singing together with meaning and purpose, with Jolie clapping her hands and raising her eyebrows, clearly having her own moment of realisation. My thinking here was that these vocal exchanges had brought Jolie's 'Sense of a Subjective Self' into consciousness, which enabled her to consciously share her affective state with me. Developmentally this is generally seen in children between 7 and 15 months of age, and indicated a significant move forward for Jolie.

From this point in the therapy each session built on the next at such a pace that we were developing the themes together from week to week. I could now introduce vocal ideas which Jolie would repeat, her voice sometimes vocally jumping up or down quite demanding melodic intervals. We also embellished our singing with rhythms played on the bongos and these became increasingly complex over the same period. To me this felt like the revolution that occurs when a baby discovers 'peek-a-boo' and can play endless variations on a theme that also involves the uncovering and enjoyment of another, with a shared affect. In this phase of therapy Jolie's world seemed to be expanding and her new awareness and enjoyment of a shared creative space was leading to greater curiosity in people and relationships. She started leaping up and looking at me when I came to collect her for her session, confirming her awareness of our relationship.

At around this time I set up a different working space, which meant that Jolie had to come out of school for her music therapy and into a larger room with a wider choice of instruments. This could have felt overwhelming for her in the earlier stages of our work together, but she was now ready for a new physical space in which she could move around and experience her separateness more completely, both internally and externally. She played the xylophone, skipping playfully up and down the notes, or experimented with a range of drums and looked at me across the room whilst I supported her playing with my own at the piano. Jolie also sought proximity by taking my hand and sitting me on the floor next to her. She would then shuffle close to me and place my hand on the guitar to play before she started singing songs familiar to us both.

This new found confidence and independence led to the next stage of our work, when Jolie began to form single words which were followed by short sentences, thus reflecting the next stage of development towards the 'verbal self'. For example, she produced a loud and jolted 'TAXI', then 'MUMMY' then 'GOODBYE', to which I would sing 'Jolie says goodbye to mummy'. This led to further verbal developments such as her singing, 'I love my pizza...I love potato', which I would repeat back and wonder aloud about other foods she might love.

Not long after this Jolie became seriously ill and needed to spend several months in hospital. I was fortunately able to visit her weekly on her ward, and was impressed by her ability to cope with her new surroundings. When she saw me with my guitar she began to sing some of her familiar melodies, which by now we had been playing together for a over two years. She also sang words to the songs, which surprised some of the nursing staff who did not know that she could speak. It felt helpful and positive that Jolie had the opportunity to connect with her 'other life' outside the hospital. Her familiarity with the music and with me seemed to enable her to reconnect with what we had achieved developmentally and remind her of her healthy potential.

On her return to school after her illness Jolie seemed more mature and emotionally resilient than previously. However, due to her ongoing illness involving a tube feed, she had now lost the majority of her language and was on a liquid diet. She looked at me frequently and clearly wanted me to be close, and to sing together with her. I was encouraged by her, that she remembered our songs and was keen to interact. She was very playful with her non-verbal voice, sometimes deliberately jumping to different octaves, smiling and gleefully

challenging me to 'chase' her in our music. I had the impression that she knew how to connect with herself and with others in a way that would have been difficult to imagine in the first two years of our work together. Even though she had apparently lost some of her verbal ability, her recently discovered self-awareness was still intact and it was this that helped her to adapt to her new, similar, yet altered lifestyle.

Figure 2: Voice and Self Models to show Jolie's developments in music therapy

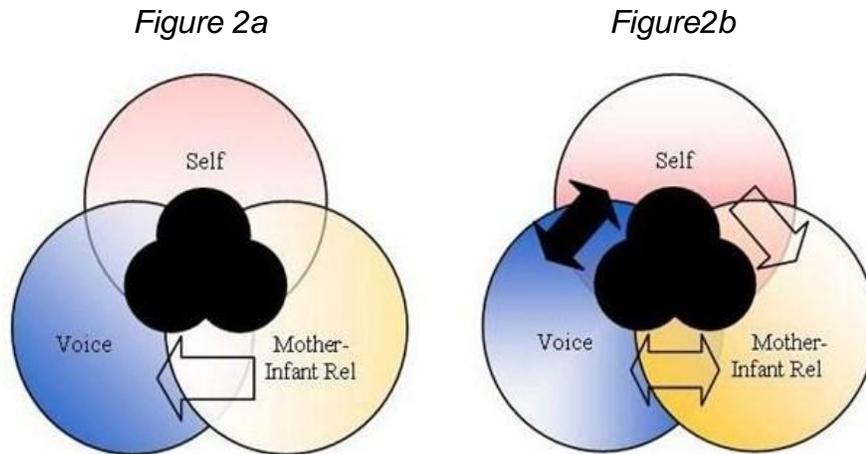


Figure 2a, representing Jolie at the beginning of our work, shows that most of her activity was within the voice itself with very little connection to others and to her sense of self. It was difficult to feel a sense of connection, within the therapeutic relationship (the Emergent Self). Figure 2b shows that Jolie has made connections with her self through vocal interactions which took place within the therapeutic relationship. This has an impact on all areas of her communication so that she is now able to enjoy interpersonal relationships and share a playful, creative space (the Subjective Self).

In this clinical example the act of vocalising took Jolie on a journey that led her to a more colourful life, one enriched with relationships which potentially continue to contribute to the unfolding of her personality that was not within grasp at the beginning of therapy. At the time of writing, these sessions continue. On less energetic days Jolie can still seem emotionally detached and revert to her repetitive egocentric behaviours; however, she and I are aware of her ability to communicate her choices effectively and to share a range of emotions with those close to her. Jolie delights in these interactions and while she still has the potential to use words, the loss of these skills during her illness has not resulted in a diminished sense of self and she is able to use her non-verbal vocabulary to share her emotional experiences. This supports my belief that vocal work alone, without language, can stimulate development of the self, and the opportunities to build and maintain relationships. In this case, it was not necessary to provide verbal interpretations for the non-verbal voice to bring meaning and change for Jolie, because this process was held deeply in the experiences themselves.

2) A clinical example of how the voice can be a container of chaos

In a group that I facilitated for young people on the cusp of adulthood the main aims were around taking control and gaining independence. With this in mind I took a non-directive approach to enable the group members to make genuine choices and to find their own way of using the instruments and their voices. At first this approach led to confusion and in some cases heightened anxiety; to a musical manifestation of chaos and disorder which felt almost unbearable at times. One member in particular seemed to be projecting her feelings of anger and inner chaos onto the group. Here it felt important that I did not step in and take control, but rather found a way to make the chaos feel contained and bearable. Again, I drew on my supervision, and knowledge of theories such as the importance of conflict in bringing in about growth and change. This music was so loud that the piano and guitar could not easily be heard and the flute somehow sounded powerless; therefore, I decided to sing a long high note, not anxious or afraid, but open and clear (a challenging task requiring a significant amount of self-composure, comparable to a mother challenged to contain a child's fears even if she is afraid herself). This had the effect of focusing the group's attention and dissipating some of the negative feelings, thereby shifting the mood in the room towards a sense of acceptance and awareness. Here we could say that it provided a 'sonorous envelope' (see section (f) of this essay) which surrounded the group members and enabled them to feel safer.

At this point group members were more aware of each other, and I developed this further by singing each of their names in turn along with a short acknowledgement of their contribution to the group. This had the effect of encouraging some of the group to use their own singing voices spontaneously and find a strength which they did not know they had. Their insecure and over-dependent 'secondary handicaps', were being challenged through this non-directive music therapy setting, which helped them to find self acceptance and assertiveness through voicework.

Figure 3: Voice and Self Models to show how the group found its voice

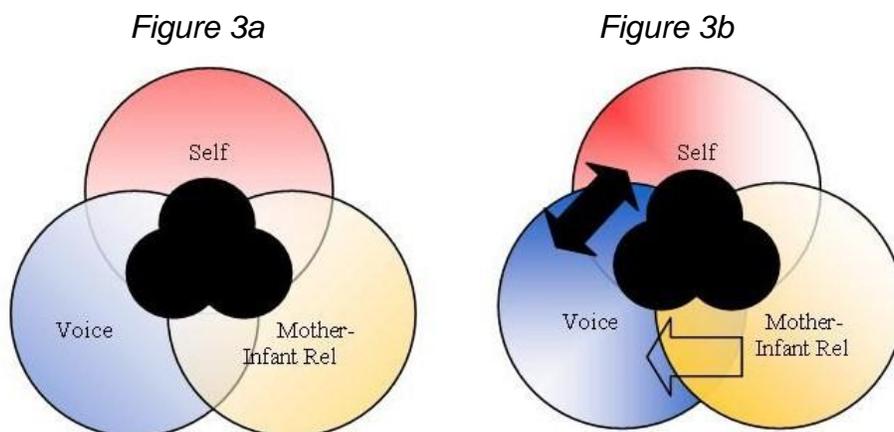


Figure 3a shows a position of minimal connection between the voice, self and therapeutic relationship within the group. Figure 3b demonstrates how a containing 'sonorous envelope' from the therapist enabled the group members to find their voices and assert their presence within the group, supporting a stronger sense of self which in turn strengthened their voices further.

3) From the voice as an empty vessel to the voice as a transitional object

The circumstances that cause me to decide against one-to-one work with a client are rare, but with ten year-old Lisa⁵ this seemed to be unavoidable. The assessment had taken place in three different settings in an effort to accommodate her needs, but none managed to contain her. Lisa was severely autistic and showed very little interest in communicating; she was fixated on clearing all surfaces of objects, pushing over or posting any she found out of the window, and then doing everything possible to leave the room. She was physically strong and if she wanted to do something it was difficult to stop her, even with a very competent assistant present for additional physical support. She showed an awareness of me comparable a sense of the 'Core Self', but was not building a relationship.

Rather than offering individual therapy or deciding not to work with Lisa, I decided to use the available space in my timetable to provide a music therapy group for her class. In this group setting it seemed most appropriate to use a directive approach and set up a predictable structure which over the weeks would become familiar to the seven severely autistic teenagers in this classroom. With the staff support, I developed songs and musical activities which encouraged the clients to function as a group, and also to notice each other as individuals. It became a positive space for all involved, including Lisa, who began to repeat the words and melodies of the songs with enthusiasm (for example, songs such as, 'Everybody play together', or 'Let's listen to (name)'). Although it was unlikely that Lisa absorbed the meaning of the words, she was able to participate and enjoy the experience in a space familiar to her, at her own pace and in a less intense environment than a 1:1 session. She could also observe the staff and her peers modelling ways of participating, and absorb the structure of the session over time.

After she had had a year in this group, I decided to try individual sessions with Lisa again. I started with the songs we had used in the group. She immediately joined in and this common ground formed a solid foundation for our work - she no longer wanted to escape. Lisa began singing a range of well-known songs (such as 'Lavender's Blue', 'If you're happy and you know it', the 'Drunken Sailor') all of which I supported with my playing on the guitar. While these were standard songs with fixed structures, I felt it was appropriate to work with the material that she brought, joining her in a familiar and enjoyable place. We sang together more or less non-stop for the entire half hour session. This continued week after week but, while I was using techniques such as pauses, cadences or varying speeds with my guitar in an effort to draw her attention to a shared and playful space, Lisa carried on regardless; she did not respond to my

⁵ The client's name has been changed to preserve anonymity.

music or to me, but rather sang to herself in a mechanical rather than emotional way.

Even though we were spending this time together each week we were not interacting. At one point during this period I decided to continue to support her songs, but to change the key randomly (again, to try to alert Lisa to the potential for relationship) and was surprised to see that she heard this and followed me, pitch perfect. The song we were singing was 'Lavender's Blue' and I found myself vocally climbing higher and higher to a 'squeak' pitch and then dropping right down to the bottom of my vocal range. Suddenly Lisa laughed and looked at me with great amusement, while still following and matching my pitch. It felt like a door had been opened, our voices were now connecting and we could play together. Here I am referring again to Winnicott's writing on transitional objects; by following my changes in key, she is allowing herself to share a space with me. This could be likened to the beginnings of the 'Subjective Self' when the infant becomes aware of the potential for playful interaction. I found myself acting like the mother who was so excited by the prospect of a relationship with her child that she naturally uses the extremities of her vocal tool to maintain his interest and motivation. As the infant's awareness progresses and he can distinguish more subtle forms of communication, the mother's vocal range begins to normalise again. With Lisa, it continues to be necessary to use these extremes to attract and hold her attention, suggesting her autism is holding her in this position which puts severe limitations on the relationship developing further, for now. However, these vocal acrobatics have shown that Lisa's motivation to follow a musical line with her voice (rather than the words carried by it) is strong enough to link her with others and notice a connection, providing a foundation for further work, based on the model.

Figure 4: Voice and Self models to show developments in Lisa's music therapy

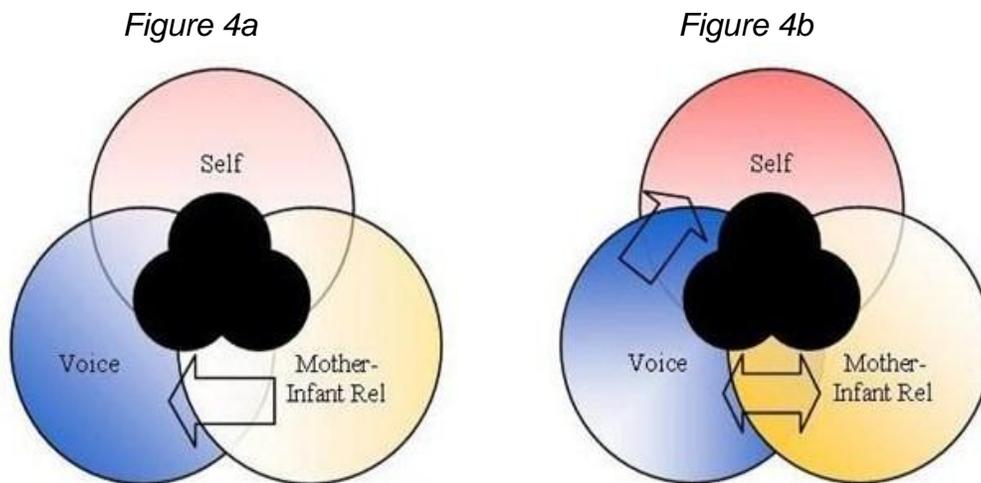


Figure 4a, representing Lisa at the beginning of our work, shows that there was some vocal activity in response to the therapeutic relationship but the sense of connection was minimal. Lisa was aware of me (Core Self), but highly avoidant

of contact. Figure 4b shows that voicework facilitated a space in which we could build connections and experience playfulness together (Subjective Self).

Concluding thoughts

The essay has considered interrelationships between the voice and the self. Theories of the self revealed links between the unique vocal instrument within our bodies and how the qualities carried within our voices both reflect and affect our life experience. Clinical experience has shown how vocal processes can affect change and growth, and the importance of moving towards a culmination of this knowledge and experience has been highlighted. I suggest remembering the instinctive nature of the vocal interactions between a mother and her baby and recommend music therapists develop an understanding of their own relationship with their voice so that they can use it as an effective therapeutic tool.

I have proposed a model to demonstrate how the self, the voice and the mother-infant relationship interrelate, wherein we can identify developmental processes taking place for the client and consider using our voice (and instruments) within this model. The model could be developed further into a three dimensional version that incorporates different stages in the process of Individuation, different types of mother-infant relationships, and different qualities and levels of engagement with the voice. These suggestions benefit from more in-depth consideration than is possible in this exploratory essay.

There is still a great deal of work to be done on understanding the processes touched upon in this essay in more depth. I have put forward the argument that the act of vocalising can facilitate self-awareness on its own, without the need for verbal interpretation. I have also suggested that non-verbal clients of any age retain the ability to use their spontaneous voices more effectively than verbal clients; this would be a fascinating area for further study. In conclusion, further research to support the theories presented here could be highly beneficial in terms of furthering our understanding of the connections between the voice and the self, and reinforcing the value of music therapy input for people who are not easily able to express themselves with words.

***Tina Warnock** is Head of Service at Belltree Music Therapy Centre in Brighton, which she set up in 2008. She specialises in music therapy with children, young people and adults with learning disabilities and autism, in combination with mental health issues. She is also a visiting lecturer for the MA Music Therapy, Roehampton University, and a vocal trainer for a community music organisation. Tina qualified from Anglia Ruskin University in 2000.*

References

- Austin, D. (1999) 'Vocal improvisation in analytically oriented music therapy with adults' in Wigram & De Backer *Clinical Applications of Music Therapy in Psychiatry*. JKP.
- Austin, D. (2008) *The Theory and Practice of Vocal Psychotherapy*. JKP
- Baker, F. & Uhlig, S. (2011) *Voicework in Music Therapy*. JKP

- Bunt, L. (1994) *Music Therapy: An Art Beyond Words*. Routledge.
- Heal, M. (1989) 'In Tune with the Mind'. In Brandon, D. *Mutual Respect*. Good Impressions Publishing.
- Holmes, J.(1995) *Introduction to Psychoanalysis: Contemporary Theory and Practice*. Florence, KY, USA: Routledge,
- Jung, C (1964) *Man and His Symbols*. Dell Publishing.
- Magee, W. & Davidson, J. (2004) 'Singing in Therapy: monitoring disease process in chronic degenerative illness'. *British Journal of Music Therapy* Vol. 18 No.2 2004
- Mahler, M. etal (1975) *The Psychological Birth of the Human Infant*. NY: Basic Books
- Newham, P. (1998) *Therapeutic Voicework*. JKP.
- Oldfield, A. (1993) 'Music Therapy with Families'. In Heal, M & Wigram, T. *Music Therapy in Health and Education*. JKP.
- Oldfield, A. (2006). *Interactive Music Therapy – A Positive Approach*. JKP
- Pavlicevic, M. (1997) *Music Therapy in Context*. JKP.
- Quinodoz, D. (2003) *Words that Touch*. Karnac
- Schneck, D.J. & Berger, D.S. (2005) *Music Effect: Music Physiology and Clinical Applications*. London, GBR: Jessica Kingsley Publishers
- Shuttleworth, J. (1989) 'Psychoanalytic Theory and Infant Development'. In Miller etal. *Closely Observed Infants*. Duckworth.
- Sinason,V. (1992) *Mental Handicap and the Human Condition*. FAB.
- Stern, D. (1985) *The Interpersonal World of the Infant*. Karnac Books.
- Streich, H. (2009) *Music in dreams*. Jung Journal. Culture & Psyche, Spring 2009, 3, 2, pp. 59-73.
- Winnicott, D. (1960) 'Ego Distortion in Terms of True and False Self' in *The Maturation Process and the Facilitating Environment: Studies in the Theory of Emotional Development*. New York: International UP Inc., 1965.
- Winnicott, D. (1971) *Playing and Reality*. Routledge