

Music as Maternal Reverie: Using improvisation to convey mindful attention in therapy.

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The best way to begin a paper on music therapy is to play a piece of music, for music therapists everywhere talk of the power of music to communicate its universality and capacity to cross boundaries and transcend artificial barriers of geography, culture, education. Passion and deep conviction as to the power of music inspire us: they have made us music therapists, producing the shared enthusiasm, which has brought us here today. So ideally a wonderful excerpt of undeniably great music could be played which would unite the audience in a feel good, receptive state ready to overlook any clumsiness in the ensuing words.

But the wish to start by playing music in fact posed an insoluble dilemma; how to choose?. Many of us have probably read or even quoted the phrase of Zuckerkandl as a rationale for our therapeutic medium "Words divide - tones unite". It sounds persuasive but may turn out to be misleading. Possibly the most divisive thing to do would be to start with a piece of music which to me was powerful, moving and heartfelt, but which left others at a loss to understand the choice of something which entirely failed to have an emotional impact on them. It is that very quality, the intrinsic potency of music, at best speaking to the deepest most inaccessible parts of the self and able to move us profoundly, that means, perversely, it can also rouse strong unpleasing emotions of alienation or irritation. Its ability to define an identity, an ideology, even a political position gives it the potential to disturb or worse to leave cold; there is no guarantee it will engender those feelings we more usually think of as benign by exciting, soothing, bringing people together, etc.

As music therapists we celebrate the power of music to have an emotional impact, and cite this along with phrases such as "music as communication" or "music can express how we feel" when explaining what we do. Bennett Reimer (1992) explores the views of several eminent composers in his book "On the nature of musical experience". For example, most provocatively, Stravinsky is said to have claimed that music essentially expresses nothing at all. It is hard to believe that when listening, for example, to a powerful performance of the Rite of Spring. Aaron Copland's words go some way to clarify that message. He says: "Does music mean something: - yes; can you say what it means- No."

Hindemith has yet another way to explain it: "the reactions music evokes are not feelings...but they are images, memories, of feelings" These words all acknowledge the potential for music to arouse an emotional response in the listener but at the same time we are reminded not to be too literal in interpreting it. There is a suggestion that the capacity to have an emotional response is awakened but that the feelings engendered may be mixed and could relate to something outside the music itself. Also, to a large extent, they will be subjective and personal to each individual listener. These are thought provoking theories for music therapists. Bernstein describes musical communication:

...the tenderness we feel when we recognise and share with another human being a deep, un-nameable, elusive, emotional shape or shade". He continues "the composer is asking has this happened to you, haven't you experienced this tone, insight, shock, anxiety release? And by reacting the listener answers yes.

For me that sums up the essence of what music offers in therapy - we find a way for something of significance to be shared.

These disparate voices are addressing an age-old unanswerable question as to the meaning of music and therefore the ways it may affect us. We will each have our own individual instinctive reaction to their opinions, sharing or opposing them according to our own personalities and musical experiences; maybe we delve into it more deeply and modify our views in the light of study or research.

Reflecting and recognising our own position (for there is no right or wrong here) is important. Our thinking about where the meaning and power of music lies - the source of its emotional impact - will shape our use of it in therapy and the choice of what to play and the ways this may or may not help our clients. Music's ambiguities, and the fact that responses to it are subjective and unpredictable, can be seen as a therapeutic strength. However, with this strength, comes the difficulties music therapists face as researchers: too much individuality, idiosyncrasy, personal experiences and associations interfere with replicating measurable responses to music.

This may be one reason why the art therapies in England, (although they are recognised by the Health Professions Council and with established posts in the National Health Service) have found themselves fitting in most comfortably amongst the psychotherapeutic professions. Behavioural and medical models of work are much less common.

Improvisation:

I am suggesting that the effect that music has on us is primarily emotive but the nature of that emotional response will not be universal or predictable. How best then to find the music that will give our clients that recognition that something "deep, un-nameable and elusive" can indeed be shared by another?

It is well known that in UK, the music therapy profession has largely (though of course not entirely) moved away from too much recorded, or even pre-composed, music within their clinical work. Instead there is an emphasis on co-creating music with our clients and particularly on the usefulness of employing free improvisation as a way to interact and communicate in therapy.

The lack of universality and agreed meanings is one factor pointing in this direction; if we can't be sure of the effect a particular piece of music will have we might want to avoid imposing our own views and tastes on our clients. We will take our cues from each individual as to what music is meaningful to them - we will LISTEN. Then we can adapt our music very carefully to help individuals find their way into a musical experience. Not knowing what this will be pushes us into uncharted territory, a place where we respond in the moment to whatever someone brings us rather than bringing in material of our own which we imagine might do someone good.

The word improvises means unforeseen and as psychotherapist Casement (1985) says 'Foreseeing may create presumptions which could blind (perhaps we should say deafen) us to clients' communications.'

Tony Wigram (2004) in his book *Improvisation* tells us first what he means by the term and then what differentiates it from clinical improvisation, using the definitions of the Association of Professional Music Therapists in Britain. He tells us that musical improvisation is: 'any combination of sounds and silences created within a framework of beginning and ending'. He says that clinical improvisation is: "the use of musical improvisation in an environment of trust and support established to meet the needs of clients".

Any combination of sounds and silences:

This is purposely the broadest of definitions to include anything from extemporisation grounded in a specific idiom to the "free improvisation" which is predominant in UK music therapy. Rachel Darnley Smith (2003) quotes John Cage who wrote in 1958 "Any sound is acceptable to the composer of percussion music" and the composer Steve Montague (1998) who said 'music emanating from unexpected places and unexpected spaces. A chaos of sound awaiting your

discovery as music' These composers are describing performance music but their thoughts apply also to music in therapy.

A framework of beginning and ending/ an environment of trust and support:

Wigram (2004) points out that clinical improvisation happens in a 'context that is clearly therapeutic' hence one point of differentiation becomes the provision of 'an environment of trust and support'. Unlike in a purely musical situation, the music generated in therapy happens between people with a very different balance of musical skills and psychological health, one person (the therapist) takes ultimate responsibility for what goes on but most importantly there is a different underlying different purpose. In performance the aim is to create a purely musical experience whilst in clinical work the resulting music is secondary to the primary therapeutic aim of promoting non-musical change

To meet the needs of clients

This clarifies the difference in purpose: in clinical improvisation the music provided will always be determined by client need. Ken Bruscia, writing a foreword to Wigrams book, feels that the underlying reason for all therapy is 'not having an acceptable alternative to one's way of being in the world' He says therapy is about 'finding, creating and evaluating alternatives'.

In music therapy the main tool we have to do this is the music, but what kind of music might that be? Our clients will have their own idiosyncratic musical tastes shaped by culture, genetic make-up, personality, and experience. They may differ in their perceptions of the various musical elements such as melody, harmony, and rhythm. The deployment of dissonance in their own musical language may be quite dissimilar to that of therapists from a western European art music tradition. Additionally, in England at least, most music therapy happens with clients who are very damaged, disturbed, ill or developmentally restricted. Their innate musicality may have survived but the capacity to make use of it is unlikely to be easy to access or immediately recognisable.

We can only start where the client is: with the sounds /silences already available to them. These could give us the basis for a new musical language to emerge: one that draws it's meaning from the particular situation, from the relationship, in which it occurs. For here is another key difference between the use of music in therapy and that of other kinds of music making: the importance of the therapeutic relationship itself as a factor for promoting change. Where better to turn for a model of a non or pre-verbal relationship than to the very first experience of it - to infancy.

Mother Infant interaction as a basis for "what to play"

Whoever we work with, be it a two year old with autistic tendencies, older children with severe learning disabilities, adults with disabling psychiatric disorders or older adults with degenerative conditions such as dementia, they will have one thing in common: huge problems with making sense of their world and of communicating how this makes them feel. The hope will be that in inviting them to join us in a musical experience we will to some extent circumvent their areas of difficulty and offer them some alternatives. It is not surprising that the emotive and non-verbal aspects of music are particularly powerful in evoking the earliest emotional experiences and re-awakening fundamental patterns of behaviour and relating laid down in infancy.

Although the extent of earliest experiences effecting us through later life might be debated it is widely acknowledged that our subsequent patterns of interacting with others and forming relationships, will to greater or lesser degree, have been laid down at the start of our lives. In particular the roots of many of our difficulties, or more dysfunctional habitual responses to stresses and strains that occur later, can be traced back to infancy. These factors are powerful pointers to using the "first relationship" - that of infant and mother figure as an analogy for that between client and therapist.

It is a model, which can provide us both with overall guiding principles and practical musical strategies for getting to know our clients in therapy and gaining an understanding of their needs. Ultimately our aim is to offer opportunities for change, which might lead to a better quality of life.

What are the conditions necessary to forge a musical relationship?

First we make sure there is a safe and consistent space - the aforementioned environment of trust and support. The overall intention is to convey a non-judgemental, warm acceptance. Instruments are provided, chosen carefully to be accessible and appropriate: they need to be inviting and attractive and for it to be easy for anyone exploring them to produce satisfying, rewarding sounds. This means good quality instruments (probably mainly tuned and untuned percussion) from many cultures and musical genres. We want to avoid a need for particular skills or musical talents to make the therapy optimally accessible - it is this that will make "free " improvisation particularly useful since it opens up possibilities and avoids inhibiting preconceptions of "right and wrong". However sparse or disorganised the sounds and silences that then arise, they are the raw material for some kind of music.

The therapist will above all listen and fully attend to the clients use of what is provided: her music will convey this by reflecting, affirming and assigning meaning to what she observes. In this model the music of the developing relationship is not expected to be beautiful or harmonious nor need it distract from painful areas of experience. As psychotherapist Patrick Casement (1985) said, our role is to 'resonate to the dissonance of others'. If our clients do come with a musical vocabulary and readiness to engage with us through it that too can be a starting point from which common musical ground can be negotiated. The key concept of 'following the client' rather than deciding for them what is most appropriate remains. Possibly when trust is established freer more mutual musical ways of being together will emerge - this often happens with clients who cling to the security blanket of their own familiar music at the start

The therapist/mother analogy: how can we make use of this musically?

Research into early emotional development, in particular the role of the mother or primary caregiver) has much we can use to inform our job as therapist. The ultimate goal of all our listening and thoughtful attention is to find the best way to give our clients a sense that we are "with" them, not "doing something" to them. In the words of Daniel Stern 'How can you 'get inside of ' other people's subjective experience and then let them know that you have arrived there without using words?' (1985,p.138).

What a great phrase to sum up the essence of establishing a musical therapeutic relationship! At the most practical level it can be helpful to look at the research of H. R. Schaffer (1977) who found he could identify distinct categories of behaviour in his observations of mothers and babies interactions. He called them "mothering techniques", labelling them: - Phasing, Adapting, Facilitating, Elaborating, Initiating, Controlling. He describes them as lying on a continuum from "passive to highly active". This apparent passivity and the idea of following rather than leading the way is often a stumbling block for accomplished musicians who aspire to become therapists.

The tendency (especially if improvising holds no terrors for them) is to overwhelm, to play too much. Here is a hard lesson: we have to make changes in habitual ways of playing that have been painfully acquired to equip us for performance in a different musical context: it may no longer be appropriate or useful to give ourselves free rein aesthetically. If we are truly to "listen" we must first make sure we don't make it impossible to "hear"! just as in performance music or jazz improvising we must "get out of the way" when someone else has something to play but how much more tricky this is when the other "player" is at a considerable musical disadvantage.

"Phasing" is the first technique and underlies the rest. By this Schaffer means that the mother continually monitors the baby's state - she is always alert to his activity and level of arousal. In the development of the mother/infant dyad she allows herself to be paced by her child who sets the level and timing of the interactions. The human voice has pitch and melody, temporal patterns and rhythm, loudness and accent, timbre and harmony. Any one or more of these may occur within the sounds a client makes and we can match it in music - just the pitch in a single note, a rhythmic motif, the length of a silence, the shape of a phrase. At this point on the passivity/activity continuum, anxious intervention may well be counter-productive for as Schaffer noted in

sequences of mothers and babies smiling at each other "-- if the mother continued to bombard the infant with unphased stimulation, then (the baby) would become tense and fretful and eventually begin to cry instead of smile".

Like a mother, the therapist does sometimes need to become a little more proactive, "**adapting**" and "**facilitating**" both musically and physically to help someone into the music. She may employ "**elaboration**" to ensure that slavishly following client cues doesn't result in a barren wasteland of meaningless mimicry. She finds the right moment for **initiation**, the bringing of a new instrument, a change of musical direction, all the time balancing the need to make sense of the senselessness against the natural inclination to make the music better and rush ahead before the client is ready.

The most active of Schaffer's "techniques" is **control**. In a therapeutic context this means making sure things are safe: nothing dangerous or damaging should happen. It also reminds us that even the most loving parent or the most nurturing therapist takes ultimate responsibility for what happens in the session. As adults around infants we all do these things instinctively and unconsciously, as musicians we may need to apply them more consciously when learning to use music interactively in the best interest of clients.

Drawing on the mothering techniques too literally could keep the therapy at quite a superficial level, more mechanical than musical. Stern's question goes deeper - he refers to the exchange and sharing of internal feeling states rather than just the outward evidence of it - the observable behaviours. He calls this "**affect attunement**" - a familiar idea to many music therapists. (Pavlicevic 1990, Sobey & Woodcock 1999). His researchers showed mothers developing ways of being with their babies which were much less purely imitative and more subtle. He describes ongoing fluid ways of "being with" rather than specific actions saying that they are "embedded" in everything which is going on.

An important aspect is the focus on cross-modal matching by which a quality of movement for instance is recast into a quality of sound. This really helps us with clients who do very little intentional sound making or anything overtly musical: they nevertheless present us with their physical demeanour, appearance, gestures, movements, all of which display the amodal properties of "intensity, time and shape" which Stern identified thus providing us with opportunities for contact and connection. He stresses that in so doing it is not the feeling itself which is shared (sadness, joy, fear) but rather the quality of feeling - such as "surging, bursting, fading".

How similar this is to some of the ideas about feelingfulness in music I touched on earlier: particularly Copland who describes music as consisting of "tension and release, density and transparency, swellings and subsidings, thunders and whispers". Thus musically and therapeutically we are reminded not to be too ready to attribute a simple category of emotion to a client's output, or to any piece of music, interpreting it mentally or verbally as obviously representing anger or sadness: rather by matching these less obvious but nevertheless intrinsically musical elements in our clients' sound world we are looking for quality of contact and those special moments when both parties recognise an affective connection.

It is always difficult to show an example of what this means in practice, for all episodes and interactions in music therapy require context to be fully comprehensible. Within a general paper of this nature there is no room for a full, explanatory case study. Although writers such as Wigram and Bruscia do identify and categorise interventions and techniques, we are cautioned not to take them too literally.

Wigram (2004) says 'the potential to accurately describe interventions is limited' and in the end what we play is not planned but depends on intuitive judgements made in the 'here and now' experience. So a model such as that of 'mother-infant interaction' can provide us with strategies

which can be helpful in learning how to use music in clinical situations; however moment by moment overall guiding principles are more important in determining what to play.

Possibly the core issue is that of "client-centeredness", the use of the music to convey "I am attending to you and everything about being with you" rather than "I have something to say...." or "there is something I would like you to do". Another helpful principle is that of treating even unintentional sounds or actions as potentially meaningful: mothers do this all the time. These things show us the stance most helpful to a therapist whatever the age or condition of the client which is why the model is not just useful for working with the young or those whose developmental age is that of a child. Whosoever comes to us for help, we will need to understand them in order to formulate goals or identify the issues most helpful to address.

Vitality we recognise it is not only the music which will make this possible but also the therapeutic relationship which that music helps to build. This relationship is not an end in itself but it is one of the agents promoting change. It will be in finding new ways of relating that a client may be helped towards that elusive goal of Bruscia's: discovering 'an alternative way of being'. For as David John wrote 'The clue to the meaning (of therapy events) is not hidden somewhere in the music but in the shared experience of client and therapist'(1994)

Listening to ourselves: influences from psychoanalysis.

Inevitably in an interactive model "listening to the client" will involve us in paying equally careful attention to our own sounds since the music will consist of the contributions of all who take part. But there is another aspect of "listening to ourselves" which goes further than this: the attention we give to our own internal world, the emotional responses our clients arouse in us. This leads to consideration of how a **psychodynamic** approach can throw light on the process of the therapeutic relationship.

In a survey of the UK profession undertaken by David Stewart (2000) asked music therapists which models they used to inform their practise. The results showed 70% citing "mother/infant" interaction" but also 60% "psychoanalytically-informed". This certainly represents a change in thinking since I trained 20 years ago when the latter in particular was confined to quite small areas of work - for example verbal client groups, the ill or emotionally disturbed rather than those with a learning disability.

It seems there has been a growing awareness of how useful it can be to acknowledge the existence of unconscious motivations underlying behaviour and make use of the theories related to this. Doing so can enhance our understanding of what happens between people both in the therapeutic process and within staff groups and institutions. Theories of group dynamics are enlightening in and out of the therapy room. However by using an artistic medium such as music, these processes taking place below our conscious awareness tend to emerge more readily and if ignored can distort our perception of the relationship.

Reasons for music in particular to be linked to the unconscious

Links between music and the unconscious are much discussed amongst writers on art and music, not just those interested in therapy. Analogies are made between the states of mind induced by music with those occurring in dreams, play or spiritual experiences. Suzanne Langer, (1948) from the point of view of philosophy and aesthetics, writes of music occurring "below the threshold of consciousness, tinged with bodily rhythms tinged with dreams". Bernstein (1992) wrote that the composer needs "to achieve a trance-like state before anything important can emerge" whilst Cage felt that "the music can act of its own accord once one gets one' mind and desires out of the way" - implying that an overly intellectual approach or too much conscious deliberation may hamper creativity.

Music educationalist Keith Swanwick (1988) tells us that Sartre compared music with an induced dream for which the end is a " passing into reality..... an actual waking up" - I am sure we can all recognise that feeling from our own particularly intense musical experiences, whether as a listener or performer; when the response has been a profound, there is an almost shocked, silence as the last note dies away; we hang on - reluctant to return to the "real world". But Swanwick continues that unlike sleep (where dreams happen) in music "we come to feel MORE not less. We are not held in sleep but pushed towards heightened awareness, greater consciousness". I like this as it reminds us we not going to be borne away into some kind of trance, out of touch with reality, but rather that our dream-material, music arising from within the improvisers, becomes accessible to our thinking selves.

So when we invite someone into music therapy, whatever this entails in our own particular model of work, we offer them music and therefore the possibility of an experience which may be intimate and profound. We think this will have the potential to change something for them whether to lift their spirits, to calm, to energise or gain relief from some pain of mind or body. We may agree with the writers quoted and anticipate that this musical experience could access some very deep rooted emotional responses, memories not just of music heard in the past or the events connected with them but also of other times feelings were stirred, other relationships where intimacy brought both extreme pleasure or devastating disappointment.

The ability to engage with what the music therapist offers may be coloured by these previous happenings, and the therapist in turn instinctively responds to how she is being related to; in both

cases this may include unconscious as well as conscious aspects of the self. How vital then not just to listen to our feeling responses but to pay them attention and consider when and how they are engendered. This is one way of describing the psychodynamic concept of "counter-transference" as a tool for deeper understanding of our clients' internal worlds and the ways we are managing or not managing to work with them in music.

My own tutor Pamela Bartram (1988) summed up this approach by saying "the quality of participation or lack of it, can offer insight into habitual ways of behaving and relating which may be unconscious and deep-rooted.... She continues, "this does not predestine someone to a life of mishaps rooted in an unchangeable past. Rather it is constantly either confirmed or modified by new experiences and within the boundaries of a therapeutic relationship different ways of feeling and relating may be experienced. " There are then choices we can make as to the use we make of the insights gained but the usefulness of reflection is certainly not confined to those who choose to make verbal interpretations in a traditional psychoanalytic way.

Reverie and containment

Such thinking can add another dimension to the mother infant relationship model and this is implied in the use of the words "maternal reverie" in the title of this paper. The psychoanalyst Wilfrid Bion (1962) coined the term to conjure up the state of the mind of the mother who is so wrapped up in her baby it is almost "dreamlike" - another analogy with how we feel when caught up in music. He tells us it is this absorption that allows her to meet the baby's needs and manage not only his total dependency but the intensity of his feelings. Anyone who has been with a distraught and crying baby will know the panic this engenders and the despair which comes with not knowing how to restore equilibrium.

Bion goes on to hypothesise that there is more to mothering (whoever does it!) in dealing with the extremes of infantile feeling states than just practical caregiving or even empathy: for optimum mental health and emotional development a child needs a mother figure who not only receives his feelingful communications but processes them and helps him develop the strength and independence to manage them for himself. I am describing **containment** here, a word used frequently by therapists and caring professionals but in this case with a very precise definition: "the state of mind in which it is possible unconsciously to be in touch with communication of pain and expressions of pleasure....to be able to engage with them if calm and loving or modulate them if distressed and hating and to hand them back in recognisable and now tolerable form". (Waddell 1998). The way this happens at the beginning of life will shape the individual's capacity to deal with difficult circumstances later on but as Pamela Bartram said it is not unchangeable.

Therapy can perhaps offer what is sometimes called "a corrective emotional experience"; one of the most useful ones being to find out that emotions thought to be overwhelming can in fact be contained. Music is a great medium for giving recognition to chaotic confusing feelings but expressing them in a limited, acceptable way.

Just as opinions and feelings about music are so individual and varied, so too are our reactions to the ideas discussed in this last section of the paper. To those who employ a psychoanalytical model in their work it could seem that I am just skating over theories and practices which require much deeper exploration and additional training. Others may think, on the contrary, that this way of thinking has little to offer in their model of work or their understanding of human development. However, as one wise psychiatrist put it to me the notion of transference "helps us not to take things personally". Realising that some of the feelings directed at us belong in part to figures from the past, protects us from feeling inappropriate amounts of inadequacy or rejection when someone discounts the music we offer.

Conversely a good musical experience can lead our clients to treat us in an "idealised" way and we may need to remember that we are not magic healers or the only person who really understands them. The consequences of ignoring this can easily be seen where the client views

the music therapist as “good” and the other helping professionals as being uncaring and harsh – an enactment of the psychoanalytical concept of “splitting”.

Awareness of these tendencies (to be seen in ways not always related to who we really are or what we have done) will help us set boundaries in the most appropriate way and keep things in the “here and now” if that is the most helpful thing to do. Thus we can stop ourselves behaving in ways that actually confirm unhealthy imaginings or beliefs in those patients who have difficulty with differentiating between reality and fantasy. We can at least consider that the discomfort or alienation that we experience when in touch with confusion, depression or “madness” could be an insight into the state of mind of the client not just a manifestation of personal weakness. Maybe these thoughts will help to demystify what are often thought to be complex theories applicable only in specialised situations.

I suggest that we could sum up the key points from this approach. They can be useful in whatever way we chose to work:

- Therapy is about "being with" someone rather than "doing something " to them.
- All behaviour can be considered as potentially a communication
- It helps to reflect on how much our own feelings may be due to counter-transference
- Skills develop within affective relationships

That last point is an important one since it to some extent addresses doubts that may arise as to the practical value of emphasising the emotional impact of music rather than how it effects us physically or how to use it to manage behaviour. Whether we work in education, with those who have a learning disability, or with older adults, their functioning can all too often be affected as much by their state of mind as by their pathology. We all falter in learning and in our relating when we have too much on our mind. A space to explore emotional issues can free someone from the impact of these and allow them to make better use of educational and practical help.

The richness of music therapy lies partly in its diversity, there is no best way to train, to work, to be a professional. We can chose our own preferred approaches to fit our situation, client group, work setting, professional colleagues; we can be directive, educational, behaviourist or we can be client centred, humanistic, or a hundred and one variations on any of these. We can play recorded or live pre-composed music with expectations for our clients as to whether they listen or take part. The myriad of ways that music can be used to bring a better quality of life to those we work with are what make music therapy conferences so exciting.

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