A Music Therapist's Exploration of Vocal Psychotherapy and Somatic Experiencing: A Heuristic Self-Inquiry

Carolyn Neapole

A Thesis

in

The Department

of

Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements

for the Degree of Master of Arts (Creative Arts Therapies, Music Therapy Research Thesis Option)

Concordia University

Montreal, Quebec, Canada

April 2022

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the thesis prepared

By: Carolyn Neapole

Entitled: **A Music Therapist's Exploration of Vocal Psychotherapy and Somatic Experiencing: A Heuristic Self-Inquiry**

and submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Creative Arts Therapies, Music Therapy Research Thesis Option)

complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the final Examining Committee:

_____ Chair
Cynthia Bruce

_____ Examiner
Guylaine Vaillancourt

_____ Examiner
Cynthia Bruce

_____ Supervisor
Laurel Young

Approved by _____
Guylaine Vaillancourt, Chair, Department of Creative Arts Therapies

__2022__YEAR _____
Annie Gérin, Dean, Faculty of Fine Arts

ABSTRACT

A Music Therapist's Exploration of Vocal Psychotherapy and Somatic Experiencing: A Heuristic Self-Inquiry

Carolyn Neapole

Music therapists often pursue specialized trainings to obtain additional skills that will enhance their work with specific client populations or help them to address particular health concerns. When trainings may contain techniques or theoretical orientations that seem contradictory rather than complementary, it can lead to confusion for therapists in their day-to-day practice, as was the case for the current author. The purpose of this heuristic self-inquiry was for the researcher to engage in self-reflective and experiential practices and to explore her feelings and perspectives on perceived disparities between vocal psychotherapy and somatic experiencing techniques used within her music therapy practice. Data collection and analysis procedures integrated components of vocal psychotherapy and somatic experiencing and were conceptualized within Moustakas' six phases of heuristic inquiry. Content analysis of the material that emerged resulted in three overarching categories: *personal insights, clinical insights, and insights about my professional identity*—each one containing sub-categories supported by personal explications, journal quotes, and audio excerpts from self-reflective experiential improvisations. A creative synthesis of results and vision for moving forward was realized within the form of a sound collage, built from layered audio samples taken from the improvisations. Multiple implications are discussed, and the researcher offers concluding remarks about the multi-faceted value of reflective practice.

ACKNOWLEDGEMENTS

My profound thanks go to the people in my life who loved and supported me as I navigated the journey of completing my graduate studies and this thesis. Thank you to my family for loving me and providing me with a life where education was always possible and valued. Thank you to Susan Summers and Stephen Williams for being my music therapy thesis sounding boards. You gave me good advice and drank a lot of tea with me as I thought out loud about this research adventure. To Carol Wiedemann and Kelsi McInnes (the Western Canada Dream Team), thank you for all the friendship, encouragement, and laughs throughout the last 2 years – I'm so lucky to have had you as classmates and friends.

To Sabine Silberberg, my dear friend and colleague, thank you for supporting me to find my way. It wasn't the first time and might not be the last.

And finally, thank you to my thesis advisor, Dr. Laurel Young, who guided me as I made my way from clinician to researcher. Thank you for sharing your considerable knowledge and experience with me, for encouraging me to aim high, and for helping me to produce a study that I am proud of. Our profession is lucky to have you.

Table of Contents

List of Tables

Chapter 1. Introduction

Significance and Need

Music therapy is a professional discipline in which certified professionals utilize evidence-based practices to support clients in their overall health and wellbeing. This support is achieved through the purposeful use of music within therapeutic relationships (CAMT, 2021). As a form of health care, music therapy may be conceptualized in myriad ways with people of every age and situation (Bruscia, 2014; Wheeler, 2015). Certified music therapists often pursue additional specialized trainings and qualifications to develop population and/or context specific knowledge and skills. Consequently, these therapists may find themselves struggling to reconcile contradictory ideas contained within various theories and approaches while working to identify the *best* way to practice music therapy (Bruscia, 2014).

Rather than trying to conceptualize music therapy practice in *one way,* renowned music therapy scholar Dr. Kenneth Bruscia (2014) suggests that music therapists engage in integral thinking processes, where differences (i.e., contradictions) may be viewed as "variations or options within a vast spectrum of possibilities" (p.184). Given the diverse clientele served by music therapists and differences among individual clients and contexts, it seems logical that different clients would benefit from different approaches. Therefore, the foundation of best practice in an integral approach to music therapy is built upon the principle of critical inclusivity. Critical inclusivity is the act of considering all potentially relevant options for a particular client or clinical situation that are within a therapist's training and competence, and "based on credible, theoretical, or research evidence" (Bruscia, 2014, p. 182). This approach allows the therapist the flexibility to follow each client's needs rather than being confined to following the constructs of any one particular model of therapy (Lee, 2015). To be critically inclusive, a therapist must make "clear and meaningful distinctions between the various practices and concepts" they employ (Bruscia, 2014, p.183). The inclusion of newer therapy models along with more traditional ones also serves to increase the tools available to a therapist when working with the complexities of each client's life (Bruscia, 2014; McFerran, 2010).

However, as Bruscia (2014) acknowledges, being a critically inclusive practitioner is not without challenges. Having an inclusive practice asks a lot of a

therapist, requiring them to be “flexible, not fixed” (Bruscia, 2014, p. 187) in their thinking, their choices, and their self-evaluation. That flexibility includes knowing when to firmly adhere to a therapeutic model or when to be adaptive with their therapeutic approach, a decision that is informed by understanding the client and the context of their life (Bruscia, 2014). A critically inclusive therapist manages a great deal of information, observation, and decision-making at any given time while also tracking the bigger picture of the purpose of therapy and how it may change from moment to moment based on the changing needs of the client (Bruscia, 2014). A critically inclusive therapist may be challenged to hold the many and varied approaches to therapy in a “coherent, integral matrix” (Bruscia, 2014, p. 184).

To manage and contextualize the challenges of the work, a critically inclusive practitioner engages in reflexive practices. To be reflexive means to, “direct one’s thoughts back onto oneself: to examine one’s theories, beliefs, knowledge, and actions in relation to clinical practice” (Barry & O’Callaghan, 2014, Need for Reflection and Reflexivity section, para. 3). Ways to be reflexive can include “self-observation, self-inquiry, collaboration with the client, consultation with others, and supervision” (Bruscia, 2014, p.57). Remaining reflexive is an effective way for a therapist to evaluate and improve the quality and ethicality of their work (Bruscia, 2014). By authentically reflecting on the personal and professional components of their work, music therapists can become more competent and insightful practitioners which in turn better serves their clients (Bruscia, 1998).

Throughout my 16 year music therapy career in Canada, I have worked with a variety of populations, such as people living with HIV/AIDS, mental health, addiction, brain injuries, burn patients, and oncology. Although I was not hired expressly in these positions to work with trauma, it has emerged as a salient issue in every group of people I have worked with. Early in my career it became clear to me that I needed to understand trauma and to develop ways to work with it to meet the needs of my clients. Because working with trauma was not an explicit part of my foundational music therapy training, I initially learned about it on the job, gathering information, resources, and practical knowledge from those of my multi-disciplinary colleagues who had been trained to work with trauma.

Trauma is often caused by helplessness in the face of shock or deprivation, leading to disorder and a loss of internal physiological rhythms. It can manifest as a loss of connection to the self, to friends and family, and to the world (Austin, 2008; Levine, 2007; Van der Kolk, 2014). The psychophysiological view of trauma is that it is a state of nervous system dysregulation defined by its symptoms, or how it manifests in the body (Levine, 1997; Porges, 2011), rather than being defined by a specific, identifiable traumatic event (Levine, 1997). In other words, even if the origin is unknown, the body's experience is real, and sometimes the body remembers what the mind cannot (Ahonen, 2017). Trauma negatively affects the brain's functioning, both developmentally and situationally (Harris, 2009; Levine, 1997; Van der Kolk, 2014) and from that place of disconnection, the mind builds its understanding of reality (Levine, 2007). My experiences with clients have taught me that trauma acts as a thief, stealing a person's psychological, emotional, or physical connection to their sense of self, sometimes manifested through loss of connection to their voice. My therapeutic efforts to help clients reconnect to their voice required engaging with the source of their traumas and working with them to resolve its effect on their lives. Literature indicates that one of the most common music therapy approaches used to work with trauma is psychotherapeutic realizations of music improvisation (Ahonen, 2017; Bruscia, 1998). To begin gaining the tools I needed, I completed a specialized training (a 2-year certificate program) in vocal psychotherapy[1].

Originated by music therapist Dr. Diane Austin, vocal psychotherapy is a model of music therapy in which a therapist and client vocally improvise together over a simple musical accompaniment, providing opportunities for the unconscious to become consciously known, processed, and integrated (Austin, 2002). These musical experiences offer a "transitional space that allows clients to explore self and the world" (Lee, 2015, p. 79) while in connection with the therapist who can offer a positive, non-judgmental

[1] In Canada, counselling and psychotherapy are regulated differently in each province, which affects how psychotherapeutic music therapy models are situated in a therapy practice. This thesis study was completed in the province of British Columbia in 2021, at which time the Federation of Associations for Counselling Therapists in British Columbia (FACT-BC) was working towards regulation (CCPA, 2022).

primary relationship (Austin, 2008). As I integrated vocal psychotherapy into my practice, I saw that it was helpful for many of my clients. However, the issues that bring clients to therapy are complex and I began to see the need for more therapeutic tools to meet the diverse needs of my clients.

Through my colleagues I became aware of body-based approaches to therapy and subsequently completed a specialized training in somatic experiencing, a short-term, naturalistic approach to resolving trauma symptoms, originated by Dr. Peter Levine (FHE, 2007). Somatic experiencing techniques increase a client's awareness of their bodily sensations and orientation to the external world (Levine, 1997). This increased awareness interrupts the patterns of trauma physiology and supports more regulated physiological patterns (Levine et al., 2018). Learning to work with a person's nervous system wrought a significant transformation in my work, drastically expanding my understanding of the mechanisms of trauma and the ways in which it can be treated.

Coinciding with my professional interest in somatic experiencing, a history of intense and violent experiences at work had left me with burn out and trauma symptoms of my own, including a disconnection from my voice which manifested as a lack of interest in my own musical self-expression. Where I had previously been a very active songwriter and performer, my musical activities became limited only to what I provided to my therapy clients. Understanding that I was experiencing burnout, I stepped away from my music therapy position and pursued personal therapy to help myself and to ensure that my struggles would not negatively impact my clients (Dileo, 2021). Somatic experiencing sessions also became a part of my personal work, and they facilitated my ongoing recovery. Understanding my nervous system made it much easier for me to be compassionate towards myself when my body and mind were dysregulated.

Vocal psychotherapy and somatic experiencing are the models I refer to most frequently in my current music therapy work. However, it is interesting to note that they differ theoretically. Vocal psychotherapy is aligned with multiple psychotherapeutic theories (outlined in chapter 2). The model situates and treats trauma from a psychoanalytic perspective (Corey, 2011), using vocal improvisation to reconnect clients to parts of the self that may be fragmented or hidden. Somatic experiencing is aligned with polyvagal theory, which explains the physiological mechanisms that dictate human

responses to threat (Porges, 2011). A practitioner treats clients by carefully helping them navigate the places in their nervous system where trauma responses are stuck, releasing these responses without overwhelming the client, and returning the nervous system to a more functional, fluid state (Levine, 1997). Despite approaching therapy from psychological and physiological perspectives respectively, the models do share a common goal of helping clients to increase conscious awareness of themselves (Austin, 2008; Levine, 1997).

In spite of this common goal, I have found it challenging to freely incorporate both vocal psychotherapy and somatic experiencing into my practice. I have found both to be effective in different ways to support clients to heal from traumatic experiences. It was also clear to me from progress made by my clients that I could practice best when using a mixture of music therapy and non-music therapy techniques. Prior to beginning this research study, I was focused on the idea that I should blend the models together but found complications in that process because the techniques contained within each approach sometimes seem at odds with each other. For example, the vocal psychotherapy techniques of vocal holding and free associative singing provide a "consistent and stable" (Austin, 2008, p.146) musical experience to facilitate achieving depth in the client's psychological exploration (Austin, 2008). Alternately, somatic experiencing practitioners often intentionally slow the pace of the client-therapist dialogue to redirect the client's attention to somatic information that might lead to the recalibration of arousal in the nervous system (Levine, 1997). These differences in the ways that tempo and rhythm are employed in the approaches is indicative of the types of contradictions that have led me to question if it is possible for me to seamlessly use both approaches in my practice.

Although there is some literature that examines the relationships between music, music therapy, and somatic experiencing (Bosco, 2010; Levit, 2018; Levine, 2007), I have not yet found any literature that explores the inclusion of both vocal psychotherapy and somatic experiencing within the same clinical practice.

After having been introduced to the concept of critical inclusivity (as previously described), I came to realize that my focus on the differences between these two models had caused me to become entrenched in a cognitive bias of incompatibility, what Bruscia (2014) refers to as "one-way thinking" (p.182). Rather than remaining stuck, I decided to

engage in a cycle of reflexivity so I could understand how to best situate myself within these approaches—as a person, a music therapy clinician, and a music therapy professional.

Therefore, the purpose of this heuristic self-inquiry was to use reflective and self-experiential practices to explore my feelings and perspectives on the use of vocal psychotherapy and somatic experiencing in my music therapy practice. It is my hope that the process and outcomes of this research will resonate with therapists who feel stuck in some aspect of their work or perhaps motivate others to engage in reflexive processes relevant to their own professional development.

Research Question

My primary research question was: what insights emerge about myself, my clinical work, and my professional identity when I (a music therapist) engage in reflective and experiential self-inquiries that incorporate elements of vocal psychotherapy and somatic experiencing?

Assumptions

Prior to conducting this research, I held assumptions that are important to acknowledge because they informed my research question and my approach to data collection. I assumed: (a) that both vocal psychotherapy and somatic experiencing are useful models for treating trauma, (b) that there may be multiple truths related to my experience of including the two models in practice, and (c) that engaging in reflective and experiential self-inquiries would positively influence my clinical practice.

Definitions of Key Terms

To further situate this heuristic self-inquiry, there are multiple key terms to define. The purpose of the study was also to gain *insight*, which is defined as the power to or act of seeing into a situation to understand its inner nature (Merriam-Webster, n.d.). I sought insights about me, my clinical work (the use of vocal psychotherapy and somatic experiencing in my practice), and my professional identity. In anticipation of a possible overlap between these three realms, I defined *personal insights* as any insights that were relevant to me regardless of my choice to work as a therapist. *Clinical insights* were defined as those that impact the relationship I have with my clients and my therapeutic

interventions, and I defined *professional identity insights* as realizations that inform how I think about and how I present myself as a professional.

A music therapist is a trained, certified clinician who uses music purposefully within therapeutic relationships to support development, health, and well-being. Music therapists use music safely and ethically to address human needs within cognitive, communicative, emotional, musical, physical, social, and spiritual domains (CAMT, 2021). *Reflective self-inquiries* are contemplative activities designed to help a therapist understand their own emotions, beliefs, and attitudes (Bruscia, 1998). In the present study, these also incorporated *experiential* components which involve the application of arts modalities to create experiences in which I explored practice-related issues through creative means (Bruscia, 1998). The specific components of these self-inquiry processes will be presented in Chapter 3.

Vocal psychotherapy is the psychotherapeutic use of vocalizations in improvisation, song, and/or dialogue, bringing information from the unconscious into the conscious mind to affect intrapsychic and/or interpersonal change (Austin, 2008). *Somatic experiencing* is a body-based approach to understanding trauma by its symptoms and renegotiating the effect it has on the body (Levine, 1997). Both models will be further explained in Chapter 2.

Summary of chapters

I have organized this heuristic self-inquiry into 5 chapters. Chapter 1 outlines the significance and need for this inquiry as well as my personal relationship to the topic. The purpose, research question, and assumptions were presented, followed by definitions of key terms. Chapter 2 presents literature related to the topic of study and is organized under the following main headings: vocal psychotherapy, somatic experiencing, and self-inquiry as a research methodology in music therapy. Chapter 3 details the heuristic self-inquiry methodology that was utilized, including the specific data collection and analysis procedures. Chapter 4 contains the results (i.e., illuminations) of the data analysis along with explications of these results supported by relevant literature, audio excerpts, and personal quotes. Finally, Chapter 5 contains a creative synthesis in the form of a sound collage built from audio samples of the original data collection. The sound collage serves as a representation of my emerging understanding of how the insights gained from this

research process informed and transformed the relational constellation of me, my clinical work, and my professional identity. Limitations of the study are presented, followed by personal, clinical, professional identity, education and training, and research implications, and my concluding remarks.

Chapter 2. Related Literature

The purpose of this chapter is to present an overview of literature and synthesis of information related to the three main topics contained in my primary research question: vocal psychotherapy, somatic experiencing, and self-inquiry in music therapy.

Vocal Psychotherapy

Psychotherapeutic music therapy. Approaches to psychotherapeutic music therapy are used to address a variety of psychological and emotional client needs where the unconscious plays a role in the presenting issue (Wigram et al., 2002). The most common theoretical orientations include psychodynamic, cognitive, and behavioural music therapy (Bruscia, 2014). In the psychodynamic orientation, musical improvisation is a common treatment intervention (Ahonen, 2017; Bruscia, 1998) and its use in the treatment of trauma can integrate personality with feelings through the creation of musical images and metaphors (Ahonen, 2017). It can offer a "spontaneous yet boundaried environment" (Sutton, 2002, p. 35) which promotes embodiment, a state of being that is often disrupted by the symptoms of trauma (Sutton, 2002). Vocal psychotherapy is a psychotherapeutic model which employs vocal improvisation techniques to uncover, explore, and ultimately integrate the unconscious psyche (Austin, 2008). The psyche can become fragmented by a variety of life experiences or traumas that injure a person's sense of safety, their self-esteem, or their emotional development (Austin, 2008). Integrating the unconscious psyche starts by finding access to lost or disowned feelings and personality aspects, then understanding and accepting them, and ultimately finding a way to relate to them (Austin, 2008). Dr. Diane Austin's vocal psychotherapy model is used to help clients reconnect to "lost or hidden parts of the self" (Austin, 2008, p. 132) from these types of traumas, aided by a trusted vocal psychotherapist with whom clients can have reparative emotional experiences (Austin, 2008).

Fundamental tenets of vocal psychotherapy. The theoretical roots of vocal psychotherapy lie in Jungian psychology, objects relations theory, intersubjectivity, and trauma theory, and a vocal psychotherapist uses countertransference as a tool to relate to and better understand the client (Austin, 2008). Countertransference occurs when a therapist reacts or responds to clients with their own psychological conflicts, and when it

is unconscious, it can cause the therapist to lose their objectivity in the relationship (Corey, 2011). When therapists over-identify with their clients, roles in the therapeutic relationship may get confused (Bruscia, 2014). It is therefore important for the therapist to have their own clear sense of self and be consciously awareness of their countertransference because, "the threshold between self and other can become slippery when therapist and client have overlapping issues" (Austin, 2002, p. 243).

Jungian analysis examines a client's psyche symbolically, which Austin (2008) indicates is preferable to the "pejorative diagnoses" of the medical model (p. 38). Object relations theory emphasizes external or interpersonal relationship as a key component to self-development (Austin, 2008; Corey, 2011) as does intersubjectivity, with the later emphasizing a collaborative, interactive, non-authoritarian therapeutic approach between client and therapist (Austin, 2008; Corey, 2011). In vocal psychotherapy sessions, a collaborative musical process can lead to increased trust and intimacy in the therapeutic relationship (Austin, 2008).

Trauma theory explains that traumatic experiences result in an interruption to a person's sense of self (Austin, 2008; Levine, 1997, 2007). This interruption usually results in feelings of helplessness and immobility or numbing, which can manifest psychologically and physiologically (Ahonen, 2017; Levine, 1997, 2007). Understanding that it can be "excruciatingly difficult to put that feeling of no longer being yourself into words" (Van der Kolk, 2014, p.239), vocal psychotherapy offers a musical environment within which the method of self-expression is flexible. The model offers the potential for reparative relational experiences that build a client's sense of self (Austin, 2008). When musical experiences are co-created, there is an opportunity for equality and mutuality with no rush towards language or the need to assign meaning to experience (Levine, 2007). The vocal psychotherapy model can also be adapted; Austin (2008) pointed out that the free associative singing technique had evolved since it was created and could be varied to meet unique or individual needs. Although the theory and techniques of somatic experiencing are not explicitly included in vocal psychotherapy, Austin refers to somatic treatment of trauma as one of the therapeutic approaches she was mindful of while formulating her model (Austin, 2008).

Vocal psychotherapy techniques. In vocal psychotherapy, the two main improvisation techniques utilized are called vocal holding and free associative singing (Austin, 2008). In both techniques the therapist provides a predictable and stable musical accompaniment along with a variety of vocal interventions to usher a client through an exploration of their unconscious (Austin, 2002; Austin, 2008). In vocal holding, the client and therapist vocalize or sing syllables and sounds (as opposed to words) over two repeating chords as a way of accessing the unconscious mind and having more spontaneous self-expression (Austin, 2008). Circumventing a reliance on verbal processing to access the unconscious, creative arts therapies techniques like vocal holding can treat trauma even if the client does not have language for or explicit memories of traumatic experiences (Harris & Fallot, 2001).

Free associative singing is Austin's name for the vocal holding process when a client uses words to express whatever comes into their mind (Austin, 2008). It is a stream of consciousness exploration that not only *holds* the client's self-expression, but adds momentum to the improvisation process (Austin, 2008). In both techniques, the therapist vocalizes in such a way as to support and encourage the client's self-expression and self-exploration while playing two chords (usually on piano) to facilitate and contain the experience (Austin, 2008). The repetition of these chords in a stable rhythm is intended to provide a safe, predictable musical space in which a client may explore the parts of their psyche, feelings, and sense of self (Austin, 2008).

Austin (2008) recommends a variety of vocal interventions as preparation for engaging in vocal holding or free associative singing, including breathing, exploring natural sounds, toning, chanting, and singing simple songs. The therapist uses their voice to provide grounding notes, unison, mirroring, and harmony as the main musical interventions that support the client's expression while meeting their developmental, attachment, and emotional needs (Austin, 2008). Trauma symptoms tend to evolve over time, physiologically re-enacting the original experience while also intensifying as the body tries to manage the repeating experience (Levine, 1997). Vocal psychotherapy "provides a consistent, therapeutic relationship within a safe musical container that can also act as a catalyst for therapeutic regressions to occur" (Austin, 2008, p. 66-67). Through vocalizing and singing, clients can include fragmented parts of the self in the

musical experience, integrating them over time and lessening the need to re-create and repeat traumatic patterns (Austin, 2008).

Summary overview of research findings. Vocal psychotherapy is a relatively young model of music therapy and as such, related literature is limited. However, there is literature that indicates the usefulness of the model as a form of clinical improvisation. Zarate (2015) conducted a multiple single-subjects design study in which forms of clinical improvisation, including vocal psychotherapy, were used to treat anxiety in adults. Results indicated that the subjects experienced a significant decrease in anxiety symptoms between the baseline measurement and the end of the 12 week treatment period (Zarate, 2015). The author reported that vocal psychotherapy techniques facilitated expression of anxiety by allowing subjects to discover and connect with different aspects of their voice (Zarate, 2015). Iliya and Harris (2016) interviewed creative arts therapists who participated in a single improvisation that used an adapted version of vocal psychotherapy to process bereavement. Through inductive thematic analysis, the authors found themes such as profound emotional expression and opportunities for grief resolution (Iliya & Harris, 2016). Six of the nine subjects reported that the music helped them access unconscious feelings, five of the subjects reported feeling overwhelmed by the intensity of the experience despite the grounding exercises in place, and all of the subjects reported that the conditions of the session provided containment for their experience making it more tolerable and at times, enjoyable (Iliya & Harris, 2016).

Somatic Experiencing

Therapy from a somatic perspective. Somatic experiencing is a body-based therapeutic approach that aims to resolve trauma symptomology by having a client and therapist engage in dialogue as they track somatic information in the client's body (Levine, 1997). Aiming to help the systems of the body function in coherence with each other (FHE, 2007), practitioners help clients to track changes in their autonomic nervous system to reveal unresolved threat responses (such as fight, flight, and freeze) that have left the nervous system dysregulated (Porges, 2011). Interrupting repeating trauma cycles and supporting the completion of innate self-protective responses can regulate the body (Levine, 1997). Practitioners may also use touch to heal somatic trauma patterns that cannot be reached by tracking sensations with the client (FHE, 2007). Touch is applied at

specific places on the body where muscular, vascular, neurological, and respiratory systems meet, facilitating a more regulated relationship between these systems (FHE, 2007). The fundamental goal of somatic experiencing is to increase a client's interoception (the ability to access bodily sensation) and exteroception (the ability to orient to the outside world) to better assess the functionality of the client's nervous system (Levine et al., 2018). Clients are supported to identify trauma symptoms as they occur, to recognize those physiological patterns, and to find ways to regulate nervous system arousal when their system becomes hyper or hypo-aroused (Levine, 1997). The negative effects of trauma can be resolved or *renegotiated* by moving slowly and rhythmically between noticing trauma physiology and healthy physiology, what Levine (1997) calls, "circling around the peripheries of the healing and trauma vortices" (p.199). Deliberately drawing attention to the healthy, fluid, and regulated parts of their nervous system builds a client's capacity to "effectively process environmental signals without becoming too reactive or too withdrawn" (Kain & Terrell, 2018, p. 122). In other words, clients can respond as needed to their environment, and return to a more neutral state when there is nothing to respond to. Somatic experiencing practitioners must develop a refined somatic awareness and the capacity to self-regulate so they can provide a co-regulation experience to their clients (SEI, n.d.).

Fundamental tenets of somatic experiencing. Somatic experiencing is supported by the polyvagal theory, which developed from the discipline of psychophysiology that emerged in the 1960s, the purpose of which was to investigate how physiology was affected by psychological changes (Porges, 2011). From this line of questioning, psychologist Dr. Stephen Porges created the polyvagal theory, which explains the evolution of the hierarchical nervous system mechanisms that control physiological changes (Porges, 2011). According to Porges (2011), unresolved arousal in the nervous system can leave the system over or under aroused, which can cause future mistakes in threat assessment. In other words, when circumstances interrupt the nervous system from doing its job, it sometimes gets stuck and requires help to regulate back to a functional place. Levine (1997) identified that the threat response cycle follows a predictable sequence: startle, brief immobilization and bracing, defensive orienting response, and, if a threat is found to exist, self-protective responses mediated by the

autonomic nervous system. Self-protective responses include social strategies, mobilization of fight and/or flight, and if all else is unsuccessful, then freeze (Levine, 1997). It is a cascade response (Levine et al., 2018). Somatic experiencing is particularly useful for people prone to overactive or underactive states (Levit, 2018) and a key component to the success of the model is to work on small amounts of traumatic material while focusing on the body and allowing emotions and cognitions to be addressed secondarily (Leitch et al., 2009).

Somatic experiencing techniques. Working somatically allows the client and therapist to monitor the level of arousal in the client's nervous system. Through the application of somatic experiencing techniques, the client's nervous system learns how to regulate that arousal to appropriate levels for what they are experiencing at any given moment (Levine, 1997). Practitioners help clients to track their bodily sensations, images, behaviours, affect, and meaning making (FHE, 2007) as a way of increasing their capacity to be able to feel and think simultaneously (Kain & Terrell, 2018). Clients are directed to bring their attention to the external world and then to their internal experiences while also being supported to pendulate between the regulation and dysregulation in their system, with the exposure to the dysregulation being carefully titrated (Kain & Terrell, 2018; Levine, 1997). Interoception (the awareness of internal experiences) is valuable because it provides information about how a person feels in reference to their environment (Kain & Terrell, 2018). An interoceptive vocabulary allows one to understand and voice their needs while informing how they see themselves, how they behave, and how they assign meaning to their relationships with others (Kain & Terrell, 2018). There are numerous other somatic experiencing techniques, including tracking defensive responses, directed pendulation, working with different types of images, coupling or uncoupling patterns in the body from each other, and the use of touch to stimulate regulated body responses, to name but a few (FHE, 2007). All of the techniques serve the goal of helping clients be able to respond to environmental stimuli with a self-correcting nervous system, also known as a healthy window of tolerance (Siegel, 1999 as cited in Kain & Terrell, 2018). By teasing apart the relationship between fear and immobility, clients can reclaim their natural self-protective instincts and behaviours (Kain & Terrell, 2018), thereby moving out of immobility and into "flexible,

resolvable patterns" (Levine, 1997, p. 117). In other words, when the body has access to its innate ability to protect itself, trauma symptoms can start to resolve. The reparative work is done by tracking sensation and developing a person's capacity to experience nervous system activation and deactivation without becoming overwhelmed (Kain & Terrell, 2018). While tracking sensations there is less emphasis on the narrative of the trauma, which is helpful in a variety of circumstances: when there is no narrative, when the narrative is unclear, or when the narrative leads the body back into the patterns of trauma (Kain & Terrell, 2018). It is also helpful when the narrative is unspeakable because clients suffer the "speechlessness that comes with terror" (Van der Kolk, 2014, p. 245).

Summary overview of research findings. Citing a lack of a review on the effectiveness of somatic experiencing, Kuhfuss et al. (2021) conducted a scoping systematic review of relevant literature, resulting in the inclusion of 16 studies with a variety of objectivist designs. The review found that 10 of the 16 included studies reported a pre- to post-treatment change in trauma symptoms, and while it goes beyond the scope of this chapter to present the findings in detail, the review found preliminary positive effects of somatic experiencing on post-traumatic stress disorder (PTSD) related symptoms, as well as somatic symptoms, and measures of well-being in traumatized and non-traumatized subjects (Kuhfuss et al., 2021). Included in the aforementioned review, Leitch et al. (2009) conducted an exploratory study that used somatic experiencing to treat a group of social workers working in a natural disaster zone. After three months, the trauma symptoms of both the control and treatment group had increased, but less so for the treatment group, who also showed higher resiliency scores than the control group. Brom et al. (2017) conducted the first randomized control study of somatic experiencing for the treatment of PTSD. The statistical results indicated a large effect size on PTSD and depression symptoms, and somatic experiencing was judged to be an effective treatment for PTSD. Winblad et al. (2018) found that studying to become a somatic experiencing practitioner was effective at improving quality-of-life and resiliency scores in professionals who engaged with traumatic events and traumatized individuals. This study's authors acknowledged limited generalizability of the results due to convenience sampling, no control group, and a high attrition rate. Yachi et al. (2018) conducted two

experiments on adults with and without trauma respectively, with both groups receiving a specific touch regimen from a trusted therapist. This touch regimen was designed to support the HPA axis (hypothalamus, pituitary, adrenal), the known control of the body's stress reaction (Yachi et al., 2018). Both groups experienced significant increases in indicators of parasympathetic nerve function indicating increased regulation (Yachi et al., 2018). Cumulatively, these studies suggest promising evidence, but this should be interpreted with caution about due to the limitations of convenience sampling and the exploratory nature of the studies.

Reflexivity in Music Therapy

The role of reflexivity in practice. In order to continue developing and improving as professionals, therapists should participate in reflexive practices, which involve the conscious awareness, evaluation, and modification of the work they are doing with clients, all in the service of practicing with integrity (Bruscia, 2014). By engaging in reflexivity, therapists scrutinize themselves; and when they do so honestly, this contributes to a more ethical practice (Dileo, 2021). All components of a therapeutic session can be reflected upon, and Bruscia (2014) lists the ways to practice reflexivity as, "self-observation, self-inquiry, collaboration with the client, consultation with others, and supervision" (p.57). The mental, emotional, and spiritual health of the therapist can also be reflected upon to help them investigate their conscious and unconscious biases, assumptions, attitudes, and personal needs (Dileo, 2021). Beyond assurances that the goals and methods of therapy are relevant and realistic, a significant benefit of reflexivity is to help the therapist remain aware of how their personal and professional traits inform their therapeutic work (Bruscia, 2014).

As previously described in the vocal psychotherapy section of this chapter, therapists have a responsibility to be aware of their own needs and to receive supervision and/or personal therapy in support of those needs so that they can maintain appropriate boundaries within their client relationships (Bruscia, 2014). *Appropriate* boundaries allow for a therapist to feel empathy and emotional sensitivity towards their clients (Austin, 2008) while maintaining separation between the client's life and their own (Corey, 2011). Therapists should be intentional and aware of how they are using themselves within each therapy session (Bruscia, 2014) because the use of self and music

are what a music therapist has to offer (Dileo, 2021). Written methods of reflective self-inquiry can include therapist journals, client logs, the musical autobiography of the therapist, and various forms of construct analysis (Bruscia, 1998). Austin (2008) recommends personal experience in music psychotherapy for music therapists, to help prepare them for the "intensity of the feelings and the intimacy that can occur within the therapeutic relationship" (p.93). Bruscia (1998) concurs and recommends participation in self-experiences in music psychotherapy throughout a music therapist's education and professional life.

Reflective self-inquiry can also be experiential, which is perhaps especially appropriate for music therapists considering that music therapy is by definition, experiential (Bruscia, 1998). There are myriad ways in which to engage in art-based experiences, and through this practice a therapist can explore their own experiences and investigate the nature of their relationship with their clients (Bruscia, 1998). Experiential self-inquiry can reveal countertransference with clients, giving a therapist information about what they bring of themselves into client relationships (Bruscia, 1998). Therapists should consider what modality would best suit the self-inquiry they are pursuing, considering music and/or other creative modalities (Bruscia, 1998). Connection with music uses many facets of who we are and how we understand the world, including both sides of the brain, body and mind, and our capacities for science and art (Lee, 2015), offering an experiential self-inquiry with the potential for depth and dimension.

The role of reflective self-inquiry in qualitative research. Qualitative researchers are encouraged to use self-inquiry during the research process to continually monitor their own responses to the research they are conducting. Bruscia's (2015) position is that self-inquiry is, "any attempt of the researcher to become more aware of or to understand his/her own personal experiences, concerns, needs, reactions, thoughts, feelings, beliefs, etc. with regard to any aspect of the research study" (e-book version, Chapter 11, second paragraph). Researchers are similarly encouraged to make special note of any aspects of the study that would be affected or influenced by those responses (Bruscia, 2015). Researchers who engage in reflexivity improve their awareness of the overall ethical quality of their study (Dileo, 2021). By remaining aware of personal and interpersonal factors, the researcher can use the resulting subjectivity to inform the

research process, often an appropriate choice for a qualitative study's purpose (Bruscia, 2015).

Reflective self-inquiry as a research methodology. When self-inquiry is the chosen methodology for a research study, it is important to be clear about how it differs from the reflexivity undertaken by individual therapists that was described in the previous sections of this chapter. There are areas of overlap between therapy and research, but they will differ in their intent and outcome (Bruscia, 2015). An area of overlap would be the pursuit of insights, but in therapy the insights are intended as a means to an end to benefit an individual client (Bruscia, 2015). Self-inquiry as a methodology is also intended to reveal insights, but insights that benefit the larger scholarly community, rather than just one therapist or one client-therapist relationship (Bruscia, 2015). Researchers should be clear about their intent; the intent of a researcher is primarily academic, and they look for the implications from the results of their self-inquiry that will affect their scholarly and professional communities (Bruscia, 2015). It goes beyond the scope of this paper to discuss these publications in detail but some examples of self-inquiry research in music therapy include Bell's (2018) self-reflection on her aboriginal heritage, Moran's (2018) study about his investigation of mindfulness as a music therapist, and La Roche's (2021) study on her use of vocal improvisation for self-care.

Chapter Summary

In this chapter, the practices of vocal psychotherapy and somatic experiencing were defined. The fundamental tenets and techniques of each approach were outlined, and summary overviews of relevant research findings were presented. The final section describes the role of reflexivity in music therapy practice and research, and an overview on self-inquiry as a research methodology in music therapy is provided.

Chapter 3 will present the heuristic self-inquiry methodology used to investigate this study's research question.

Chapter 3. Methodology

Design

Heuristic inquiry, originally developed by Clark Moustakas, involves a process of internal examination with the goal of discovering and understanding the qualities and meaning of an experience (Moustakas, 1990). This first-person research project was realized within a heuristic self-inquiry methodological framework, where the researcher is the sole participant, and the goal is to examine the topic of interest from a first-hand perspective (McGraw Hunt, 2016). This methodology was a suitable choice for my study because a heuristic process values many ways of knowing, such as perception, intuition, and information from the senses (Moustakas, 1990). My topic invited significant personal involvement, and as Moustakas (1990) himself experienced, the process might have been difficult or confrontational in unanticipated ways. The phases of heuristic inquiry are well suited to exploring intense, personal, and subjective experiences (McGraw Hunt, 2016).

Some delimitations were imposed on this study design. As noted above, I was the sole participant, and the timeline was designed to fit within the duration of a typical master's degree. The data collection period was limited to a 4-week period, and because a considerable amount of data was generated, only data directly related to the research question was included in the explication. The related literature that I used to contextualize my study and research findings was delimited to English language primary source books and scholarly publications published since 1990.

Validity

As Moustakas (1990) pointed out, the validity of a heuristic inquiry is confirmed if the findings emerge from an in-depth inquiry and coalesce in such a way as to accurately represent the lived experience of the participant(s). Therefore, as the sole participant, it was my responsibility to conduct the inquiry comprehensively and to report honestly about any insights or knowledge gained throughout the process. Ultimately, I needed to decide if the inquiry was meaningful to me and an accurate representation of my lived experience. To hold myself accountable to academic and methodological rigor, I consulted regularly with my thesis advisor and sought out peer supervision with three colleagues, all of whom are creative arts therapists who have completed graduate studies.

Materials

Materials included: a personal laptop with audio recording capability, a mobile phone with audio recording capability, a transcription application for converting recordings to written text, a word processing document for reflective writing, an electric piano for instrumental improvisation, and a private space in which to collect data (i.e., to engage in the reflective and experiential self-inquiry processes detailed below).

Data Collection and Analysis Procedures

The data collection and analysis procedures were conceptualized within the six phases of heuristic inquiry detailed by Moustakas (1990). These phases are designed to guide the researcher from the crisis that created the question to an expanding awareness of that which creates the lived experience related to the question (Douglass & Moustakas, 1985). The researcher gains an understanding of the patterns, subtleties, and aspects of the experience, and then has the opportunity to create a meaningful synthesis of the insights gained from the inquiry process (Douglass & Moustakas, 1985).

I integrated components of vocal psychotherapy and somatic experiencing into the data collection procedures, so as to create opportunities to uncover unconscious material that might be inadvertently influencing how I was perceiving and using these two models in my practice. Vocal psychotherapy components aimed to "support a connection to the self and promote a therapeutic regression in which unconscious feelings, sensations, memories and associations can be accessed, processed, and integrated" (Austin, 2002). I tracked my somatic experiences, speaking them aloud as I became conscious of them, which kept me connected to my interoception and while I found words to describe it. To be clear, the method of data collection was not vocal psychotherapy or somatic experiencing because both models require an interpersonal relationship with a trained practitioner (Austin, 2008; Levine, 1997), however the inclusion of some components of the models allowed for the process of self-inquiry to be both reflective and experiential while being rooted in a familiar format. The intention behind this choice was to make the method of study relevant to the issue at hand (Lee, 2015), and to frame any insights gained in such a way as to be relevant to future, real-life clinical situations.

The i*nitial engagement* phase is designed to aid the researcher in determining the problem, question, topic, or theme to be examined (Moustakas, 1990). My initial

engagement consisted of identifying a topic of interest, discussing the topic with instructors, classmates, and creative arts therapies peers, examining related literature, formulating a research question and proposal, and reviewing personal notes taken in my vocal psychotherapy and somatic experiencing trainings.

The *immersion* phase involves becoming intimately connected to the research question, co-existing with it in all facets of life and pursuing any experience that could be connected to understanding the phenomenon in question (Moustakas, 1990). In the present study, this involved my active engagement in reflective and experiential self-inquiries where I incorporated adapted elements of vocal psychotherapy and somatic experiencing. In seeking insights about my person, clinical work, and professional identity, I hoped to be fully present to my own experience of navigating the use of these therapeutic models without a predetermined goal or agenda (Moustakas, 1990). Knowing that I would have somatic responses to improvising and that those responses might contain some of the insights I was seeking, I chose to simultaneously engage with elements of both models by tracking my somatic experiences while improvising in a style informed by vocal psychotherapy. Choosing to have elements of both models present in the design of the improvisations allowed me to collect personal and clinical information that emerged somatically while improvising.

I completed six vocal improvisations over a four-week period, spaced three to seven days apart. For each improvisation I pre-recorded an instrumental piano track that included a repeating chord structure chosen in the moment and informed by my emotional state and aesthetic preference. Choosing chords in this manner was an adaptation of the vocal psychotherapy practice of providing a simple and stable musical accompaniment to contain an improvisation (Austin, 2008). I made an audio loop of a portion of the repeating chords. I then instinctively chose a location in my home and a posture in which to situate myself. Using my laptop to play the looped piano track, I recorded my vocalizations over the piano track on my mobile phone. See Table 1 for a summary of the chords, tempo, and length of each improvisation.

Table 1

Fundamental Structural Components of Improvisations

Improvisation #	Piano Chords	Tempo	Length
1	F maj / Bb maj	70 BPM	12:28
2	B min^6 / E min^7	60-40 BPM	31:15
3	Am / G maj	69 BPM	18:17
4	D maj / B min	59-44 BPM	12:38
5	C $maj^{7/9/11}$	Not recorded	20:38
6	Eb maj / F maj	Not recorded	17:32

My vocal sounds were spontaneous and included speech, singing, verbalizations, vocalizations, and other organically occurring utterances. The one exception to the spontaneity was my pre-determined choice to verbally express any somatic experiences I had as they occurred, an adaptation of the somatic experiencing technique of tracking (FHE, 2007). The length of each improvisation was also decided in the moment and informed my intuition. Directly after I finished improvising, I wrote down my reflections about the improvisation experience, using the following questions to ensure consistent and comprehensive reflection:

1. What did you notice in your body while you were improvising?
2. What did you notice in your emotions while you were improvising?
3. Are there any questions that emerged during the improvisation?
4. Are there any insights that emerged during the improvisation?
5. What (if anything) is different from before engaging in the improvisation?
6. Is there anything else from the improvisation to reflect on in this moment?

After completing the reflective journal entry, I used a transcription application on my laptop to create a text transcript from the completed improvisation. The program converting the recording to text made multiple errors, so I then listened to the recording and corrected any errors while chronologically notating any other audible content such as breath sounds, humming, and non-verbal vocalizations and sung notes. Any somatic experiences I expressed were italicized on the transcript to visually differentiate them from the rest of the content.

Following the active data collection period, I engaged in a four-week *incubation* phase where I took a break from all research related activities. The intention behind this phase is to create a period of rest after which a researcher can return to the data with the opportunity to see patterns and themes emerge from a refreshed or new perspective (Moustakas, 1990). My original plan was to have a two-week incubation period; however, I found it necessary to extend the period to fully disengage from the research process.

Data analysis in heuristic inquiry is intended to reveal "qualities and themes that encompass the research participant's experience" (Moustakas, 1990 p.48). This information emerges during the *illumination* phase when the researcher re-engages with the data. The data in this study was examined using qualitative content analysis techniques, a non-linear, iterative approach to condensing content and supporting the researcher to be actively involved in constructing the meaning extracted from the data (Ghetti & Keith, 2016). Each of the six improvisation transcripts was combined with the corresponding reflective journal entry from the *immersion* phase and entered into an excel spreadsheet. The data was divided into chronologically listed segments, or units (Ghetti & Keith, 2016) consisting of each statement, question, or idea I expressed, as well as audible noises such as breath, humming, and singing. I then listened to each improvisation recording again, documenting noteworthy musical behaviours beside the corresponding unit. Each unit was reduced to a code, paraphrased to reflect the essence of what I was communicating at the time (Ghetti & Keith, 2016). Examples of the codes I created included: *assumptions I hold about the models and how they should be used, clinical overlapping with personal/unrealistic expectations, acknowledging my strengths, querying the relationship between tempo and overwhelm,* and *desire for safety within my community*. Every somatic experience was given a code that began with the word *experiencing*, such as *experiencing intrusive thoughts, experiencing breathlessness,* or *experiencing embodiment*.

After coding my data, I began the *explication* phase, the penultimate heuristic research phase during which the researcher makes sense of and fully explains the characteristics of the research question(s) (Moustakas, 1990). During this step, I intentionally re-examined the data for any new understanding or insights, then integrated

new findings into the data coding, updating the codes as needed. I organized the full list of codes chronologically and then alphabetically, looking for patterns, frequency, and any codes that demonstrated a synthesis of ideas or discovery. I then separated the codes into the three pre-determined or deductive categories (Ghetti & Keith, 2016) drawn from my research question: personal, clinical, and professional identity. From there I grouped the codes into sub-categories defined by related content, interpreting and assigning meaning to content.

The final phase of heuristic research was the *Creative Synthesis*, my opportunity to portray and amalgamate experience and knowledge gained throughout the research process in a creative form that was meaningful to me (Moustakas, 1990). I reflected upon the chord structure of improvisation 5, which I had experienced as particularly beautiful and conducive to self-expression. My first idea for a creative synthesis was to use this piano track as a foundation for a new, themed improvisation about the research process, but while completing the explication phase I realized that there were already multiple moments of synthesis in the existing improvisations. Following an instinct that it might feel meaningful to gather them together, I created audio samples of the moments of synthesis, layered them together, and created a *sound collage*. The resulting recording resonated deeply for me because it amalgamated moments of insight, emotional strength, and reminders of how I can continue to evolve as a person, a clinician, and a professional. The development of the *sound collage* creative synthesis project was planned over a two-week period and was assembled and completed over three days.

Ethical Considerations

Due to the personal nature of heuristic self-inquiry, it is best to plan ahead for inevitability of challenges as they emerge (Sultan, 2019). In qualitative studies, it is not always possible to know what the experience of participation will be until the study unfolds (Dileo, 2021), so given that consideration, I employed multiple strategies to minimize personal risk and reinforce my self-care (Sultan, 2019). I engaged in personal therapy throughout the inquiry, I received regular supervision from my university thesis advisor, and I formed a social and informal peer support network (Sultan, 2019) with whom I shared my responses to the personal nature of the study. No content from my personal therapy sessions was included in my research.

Chapter 4. Illumination and Explication

The primary research question for this study was: what insights emerge about myself, my clinical work, and my professional identity when I engage in reflective and experiential self-inquiries that incorporate elements of vocal psychotherapy and somatic experiencing? The data coding process detailed in Chapter 3 produced 221 codes, which were sorted by relevance to three pre-determined categories contained in the research question: personal insights, clinical insights, and insights about my professional identity. The predetermined categories and emergent subcategories are presented below in Table 2.

Table 2

Summary Overview of Categories and Sub-categories

Category 1: Personal Insights
Subcategory 1a. Personal Needs
Subcategory 1b. Personal Values
Subcategory 1c. Identifying disruptive thought and belief patterns
Subcategory 1d. Musical Discoveries
Subcategory 1e. Somatic Discoveries
Category 2: Insights about my clinical work
Subcategory 2a. Clinical questions
Subcategory 2b. Clinical needs
Subcategory 2c. Professional values
Subcategory 2d. Challenging professional insights
Subcategory 2e. Inclusivity in clinical ideas
Category 3: Insights About My Professional Identity
Subcategory 3a. Realizations about my professional identity
Subcategory 3b. A foundation of fluidity
Subcategory 3c. An evolving professional identity

The rest of this chapter will describe the thoughts, perceptions, and insights that emerged to help create the subcategories that fell within the aforementioned predetermined categories. Personal explications as well as references to relevant literature are made to

further organize and make sense of what emerged. Audio samples from the improvisations and excerpts from my journal (presented in *italics*) are included where relevant as a measure of credibility to support both my results and interpretations. The personal insights category is presented first to align with the structure of the research question and because the meaning gleaned from these personal insights acted as a foundation upon which to understand the subsequent categories.

Category 1: Personal insights

Personal insights were defined as any insights that were relevant to me regardless of my choice to work as a therapist.

Subcategory 1a. Personal needs. I expressed a variety of needs throughout the data collection period, and I labelled the following three needs as personal because they would remain true regardless of my choice of profession.

In improvisations 2, 3, 4, 5, and 6, I experienced a need for more time than I expected to be able to access my emotions, cognition, or imagination with ease. In improvisation 3 I sang, *I need space. I just need space. I need space to feel. I need space to breathe*, and in improvisation 6 I sang, *it's occurring to me right now how much space and time I need in general to settle into a process and stay present within it*. I was expressing the need to have literal, figurative, and sonic space to explore my bodily experiences and thoughts. I made the decision to create space during improvisation 2 and 4 when I altered the tempo or temporarily stopped the piano accompaniment, and I believe my body claimed space during the times when I felt fatigued after improvising (improvisation 2, 4, 5, and 6). The fatigue could have been a response to nervous system activation (FHE, 2007), and I also interpreted the fatigue as a management strategy that offered me respite from the psychological and physiological stress of exploring my unconscious mind. Improvisation 3, which I completed directly after working with a client, was notable because I did not need to slow the tempo of the music to stay emotionally or cognitively present. I wondered at the time if I was more regulated when starting this improvisation because of having just led a clinical session, and that I was able to make the space I needed by breathing and pausing in my vocalizations. I plan on setting aside a generous amount of time when I engage in future self-inquiry to create the

right circumstances for my own increased regulation, and for access to my cognition, intuition, and imagination.

In improvisations 1, 4, 5 and 6, I expressed a need to stay connected to my curiosity. Curiosity emerged twice in the metaphor of a deep body of water (improvisation 4 and 6), that I wanted to engage with, as heard in an audio sample from improvisation 6 (see audio file 1), where I sang, *mmm… Here we are, here we are, here we are… The final dive into the pool. The pool of curiosity, for now. For now.* The recognition of the need to stay curious, led directly to an awareness of a third need— to spend time intentionally engaging in personal music and creativity without a professional agenda. In improvisation 6 I sang about this realization, saying *what I am aware of now that I wasn't aware of before, is that I need to be curious and plugged into my own creativity*, *my own humanity*. Bruscia (1998) suggests that music therapists must nurture their own musicality because, "the therapist's musical self is a core component of the therapeutic process" (p. 117), and my realization about my need to engage in personal creativity made sense to me when I thought about how the majority of my musical experiences had been cut off by long periods of isolation during the COVID-19 pandemic. I interpreted this need as a sign that I was experiencing a creative atrophy that would require an intentional re-engagement with music for my own enjoyment.

Subcategory 1b. Personal values. The following two values felt personal to me because they refer to ways of being in the world that go beyond my clinical work and professional identity. Early in improvisation 1, I expressed that I value being truthful, both in following and expressing the truth. I sang, *I want to be someone who tells the truth. I am judging myself and worried all the time about the idea that I'm losing my objectivity*. For me, the need for truthfulness is sometimes outweighed by my fear of conflict. This imbalance can affect my work, where, as Dileo (2021) describes when examining the virtue of courage in a therapist, I can become too cautious in my approach to challenging clinical situations. I am aware that this pattern stems from my personal life where I have been conflict-avoidant since I was a child. When expressing that I value truthfulness, I was being critical of myself thinking about what more I should be doing to enable myself to speak up when I have something to say that might be received as conflictual.

In improvisation 1, I also expressed that I value the ability to be forgiving of myself and others. At the beginning of my data collection the value of forgiveness emerged with an emotional subtext of self-criticism, which was not reflected in my words, but was something I felt. I knew as I sang about it that I struggle to forgive myself for my perceived shortcomings. Forgiveness emerged again in improvisation 6, where I sang, *perhaps also there needs to be some forgiveness for not being at my best during a global pandemic. For not being at my best during burn out. For being lost some of the time*. While analyzing the data, I identified that I have been more successful at cultivating self-forgiveness when I have had a consistent, supportive practice of personal growth in my life, including therapy, supportive social connections, creativity, and exposure to art, such as theatre and in particular, live music. It makes sense to me that having more live or shared music in my life would facilitate being more forgiving, balanced, and self-compassionate as shared musical experiences facilitate our felt sense of connection and can help us regulate (Levine, 2007).

Subcategory 1c. Identifying disruptive thought and belief patterns. Prior to engaging in the research process, some of these patterns were familiar to me, however the reflective and experiential self-inquiry process changed my relationship to them. Similar to the other personal subcategories, there is some cross over here between my person and my profession, but these patterns are included as personal because of how my person influences my profession. The insight gained was two-fold: I became more consciously aware of the vocabulary of these types of thoughts and witnessed the frequency with which they appear in my verbal expressions.

I was surprised that after many years of personal and professional growth, I still feel a lack of permission to struggle in my life, thereby holding myself to a standard I would never apply to someone else. In improvisation 2, after having explored the need for more space (as described in subcategory 1a), I sang, *I don't understand why I struggle like this*. I felt frustration and despair in that moment, feeling a sense of personal failure. When journaling after improvisation 2, an insight emerged, and I realized that I judge myself negatively for what I struggle with in life.

In improvisation 3 I sang about wanting clients to like me and wanting them to be impressed by my competence or intelligence, wanting clients to see clear, obvious value

in the therapies I practice. In an audio sample from improvisation 3 (see audio file 2), I sang, *I want the best for you. I want you to find me effective and compassionate and smart [laugh]. I want you to like me. Perhaps I also want you to admire me*, but I then experienced an emotional reaction of shame and embarrassment, expressed when I said, *oh yeah, I can feel it now. I feel embarrassed and sad. I can feel emotion coming up my throat into my eyes and I feel embarrassed and a little ashamed*, followed by my comment, *it feels important that my clients think that I'm smart. That they can trust me. That I will know what to say or what to do. That I will provide the miraculous transformation that we joked about. We joked about it, but perhaps it wasn't a joke, completely.* It was not new information to me that I had some investment in being liked by my clients, and the shame that arose made me feel like a fundamentally bad person, rather than a person with a behaviour to address. This type of shame response has been chronic in my life, and as Kain and Terrell (2018) describe, it produces a deep, body-based experience of shame, embedded in my somatic responses to stress. It is an important realization to know that my experience of shame needs to be further untangled from my self-worth.

Throughout the improvisations, I saw evidence of catastrophic thinking, which I defined as ideas and questions with absolute or extreme language. In improvisation 4 I was exploring my concerns about the effects of burnout in my life, and when I asked, *will I ever come back to myself?*, I responded with the statement, *it seems like a no-win situation, no win, no way in, no win*. What I expressed in that moment does not match what I know to be true logically, which is that I have made considerable recovery from burnout. These statements showed that my body and emotions had not let go of the burnout experience to the same degree as my thoughts had. In other words, I had understood my burnout experience on an intellectual level but had not processed it fully on a somatic level.

I believe I had compartmentalized these thought patterns, not seeing how they were accumulating and how they were feeding each other. After improvising, I could see and hear more clearly the cumulative impact of these thoughts and the ways in which they have compounded a feeling of disconnection from my sense of self and safety. Upon further reflection of the familiarity and prevalence of these patterns in the improvisations,

I questioned whether they are outdated and perhaps perseverative rather than reflective of my current professional competence.

Subcategory 1d. Musical Discoveries. During the data analysis process, I gained insight into my existing musical patterns and discovered how my musical behaviours could facilitate personal insight. The first three improvisations were started in what I later identified as typical musical pattern for me in vocal psychotherapy: a mid-tempo, vocal mid-register, 4/4 time signature decorated with suspended chords, and a breathy vocal tone. This pattern is well represented in an audio sample from improvisation 1 (see audio file 3).

I had not planned to switch from singing to speaking to express my somatic experiences, but it happened consistently until late in improvisation 3 when I started occasionally singing my somatic information. In the audio sample from improvisation 3 (see audio file 4) you hear the first occurrence of me singing a somatic experience and it begins and ends with a demonstration of how my pitch dropped when expressing my thoughts about what I want for my clients I sang, *I'm here to witness you, to encourage you towards resilience. Towards resilience. I'm here to trust you. Eureka. I wonder if I'm having issues with trusting my clients to find their way. I don't know if that's true. I felt like I needed to say it, but I don't know if that's really the actual problem. So, I breathe. And I'll practice just being with where I'm at. Instead of focusing on calming down I will just be with this energy I have right now… it's like, I'm a little heightened. I'm a little bit… my breath is kind of shallow. My hands are up as though I'm gesturing as though I'm talking to someone else. And my thoughts are a little scattered – they come in fragments. So now with my hands on my chest, I will think about my client, and I will say that… I want the best for you.*

In vocal psychotherapy there is no prescribed musical rhythm, so long as the accompaniment is stable and consistent (Austin, 2008). So, starting in improvisation 4, I chose a different rhythmic pattern on the piano because I was curious about how my vocalizations would be impacted if the accompaniment changed from what was familiar. I saw an evolution in my language choices, melodic and rhythmic exploration, and my somatic responses to the music, which began to include more positive regard for the music, such as at the beginning of improvisation 5 when I said, *Such a friendly sound,*

sweet. Sweet and comforting. Ah, I have missed you. The experience of being welcomed by the music was followed quickly by a feeling of grief. The music was beautiful to me, connecting me to my emotions (Austin, 2008) and within my emotions, grief was most present in that moment.

In improvisations 3 and 5 I deliberately used my voice as a metaphor, vocalizing in such a way as to directly represent the content of what I was expressing, using my pitch, tone, and timing to represent my ideas and my bodily sensations. I made deliberate vocal register, pitch, and rhythm choices against the tonality and rhythm of the piano, often misaligning with the beat, and singing long, discordant notes without resolution. In improvisation 3, these choices emerged as high register, discordant, sustained notes on thin folds, while I sang *give voice to the parts of us in the sustained sounds.* In an audio sample (see audio file 5) from improvisation 5 you can hear me start the phrase on a non-chord pitch and find intermittent discordant notes as I sang *I like this feeling of control with my breath. Like feeling like I can control my breath. I think that's why I hold it. Why I hold it, why I hold* it. My pitches dropped as I sang, *finally sinking down in space. Finally sinking down, down, down in space. Mmm, mmm,ooo*. While singing, *I'd like to understand better how to be in between, in between,* I deliberately finished the phrase in between chord tones. My experience of singing in this way felt creatively satisfying and was an experience of coherence, which is described in the somatic experiencing teaching manual as an integration between my thoughts and musical instincts, fluid, and harmonious (FHE, 2007). I think this integration came from more regulation in my body in combination with a spacious musical accompaniment, setting the right conditions for accessing more of my unconscious, my creativity, and my musicality.

Subcategory 1e. Somatic Discoveries. I was surprised by four distinct unexpected somatic experiences. It went against my experience of myself to feel internal permission to make significant adjustments to my body positions and postures to aid the improvisation process, yet that happened in improvisations 2, 3, and 5. For example, in improvisation 2 I chose to lie down at 8:56 saying, *it occurs to me now that I think I'm going to try this improvisation lying down because my body is feeling unsupported*. Over the next 17 minutes, I experimented with my position and posture, allowing increasing curving in my neck and torso, until finally at 25:45 I chose to sit up in an effort to be

more cognitively present in the improvisation. At that point I realized that I had moved through some kind of freeze response and collapse of my muscle tone, which in the somatic experiencing model would be completion of an arousal cycle (FHE, 2007). After this experience, I was once again cognitively present in the improvisation. I suspect that working with a recording rather than being distracted by having to provide my own live accompaniment freed me to notice how the music was affecting me.

It was common throughout the improvisations for me to feel activated (i.e., arousal in my nervous system) and to attempt to deactivate by focusing my attention on slowing the pace of my breath or putting my attention to a part of my body that felt less activated. The most successful deactivation was achieved in improvisation 4 when my attention went to the piano loop on the computer screen and I counted out loud to the beats of the music, tracking them visually as they went by. I combined my voice with the sound which pulled my attention external to my body, a somatic experiencing technique that helped me feel emotionally and physically settled (FHE, 2007).

In improvisation 5 I had a new experience of my own activation, feeling for the first time in the data collection process a desire to stay activated. I deliberately shifted my intention away from trying to feel calm to trying to notice what my body needed while in a heightened state. In that moment the activation felt powerful. I was holding my breath but felt no need to change that behaviour, and I enjoyed a sense of control from doing so. In the somatic experiencing model, holding the breath can be seen as a defensive behaviour (FHE, 2007), and I chose to be with the behaviour rather than attempting to change it prematurely. When I did eventually feel the instinct to use exteroception to lower my arousal state, it was helpful to touch an object rather than just to focus my attention on one. In combination with the experience of deactivating by counting out loud (mentioned above), I experienced that my nervous system might need a more specific kind of engagement to deactivate, being soothed through tactile stimulation. It's possible that I need to stimulate my tactile awareness to establish a sense of self, giving me, "body boundaries that help us to tell 'me' from 'not me'" (FHE, 2007, Beginning module 2, p.30).

An unexpectedly positive emotional response occurred in improvisation 4 in response to an image I experienced of a being a tiny figure skating over a deep, dark body

of water. I sang, *I'm skating on a pond. Skating on the thinnest wafer, sheet of ice. And it holds me up, holds me above. And underneath, underneath the ice it's dark but there is also life, and depth. That's where it is deep*. In that moment I saw the depth as possibilities in the unknown, which I wanted to move towards. This positive response was surprising for two reasons. Firstly, I have always been afraid of dark, deep water and secondly, I interpreted this imagery as an unexpected shift towards my increasing capacity to be with the unknown, surprising because of the energy I had been putting into staying with what is known. If my interpretation was correct and my capacity was expanding, the question remains as to what influences were increasing my felt sense of safety. Kain and Terrell (2018) postulate that a felt sense of safety comes from connecting to the neural network built when one has experienced safety in the past.

Later in the data collection process (improvisation 5) I began to have experiences of pendulation, where sensations or emotions would emerge, crest, and retreat (FHE, 2007). These experiences left me feeling grounded and alert, with a sense of completion. Perhaps as an outcome of experiencing pendulation, by improvisation 6 the continuous structure of the music provided a framework within which my activation levels were more tolerable, a distinct difference from the earlier improvisations where the music had further aggravated my level of activation. It was also in improvisation 6 where I saw an image of my body disappearing, paired with a physical sensation of being *untethered*. I became embodied again easily by placing my attention on the computer keyboard and singing about the letters I saw there. In the audio sample from improvisation 6 (see audio file 6) I sang, *it reminds me that I am also a person who is quite curious. And years, and years, and years of challenge and trauma and pain and suffering dulls me down to a broken pencil that can no longer write. And I fill that gap with chat and wine and noise, and pop culture. The flashes and pops of all the screens, and lights, and noises around me can fill that gap. And then I disappear. And I just felt myself, I just felt myself get more untethered from my body. And so, I'm feeling my breath. Feeling my breath. I opened my eyes so that I was not quite as likely to list somewhere else. And right now, it's just me and the computer, just the space in front of me, looking at the light up keys. QWERTYs [laugh], the QWERTY keyboard. It's kind of amazing that they managed to arrange the letters on the keyboard so that not a single word is spelled. Ah well, that's*

not true. We. We. As. As {breath}. The speed at which I was able to feel re-embodied and the audible breath sound at the end of the clip indicate that my overall regulation had grown. Increased regulation leads to more capacity to meet challenges (FHE, 2007), such as those that come from the exploration of the unconscious mind.

Category 2: Insights about my clinical work

Clinical insights were defined as those that impact the relationship I have with my clients and my therapeutic interventions.

Subcategory 2a. Clinical questions. The range of clinical questions that emerged during the improvisations spanned from overarching concepts about the nature of therapy to specific questions about the models I use and how to practice with them. The questions were meaningful to me because they identified the specific gaps in information that could inform me how to best practice inclusively using vocal psychotherapy and somatic experiencing.

From the beginning of the data collection process, I was seeking to better understand the nature of practicing therapy and my place in it. In improvisation 1 I expressed feeling overwhelmed related to my search for understanding, singing, *where do I begin? So many things I want to know, I want to figure out, I want to understand*. In improvisation 5 I sang, *what is the nature of what I do? The nature of therapy, of connection. Where is the spot for my humanity?* and in improvisation 3 I asked and answered a question about my role in the therapeutic relationship, singing, *What is my role here? I'm here to witness you, to encourage you towards resilience.* I felt anxiety in improvisations 1 and 5 when asking theoretical or philosophical questions about my work, but more grounded in improvisation 3 when reflecting about the specifics of what I offer clients. This specificity may have been informed by the fact that improvisation 3 was completed directly after working with a client and reminds me that I do my best work when I keep the client relationship in the foreground of my awareness, and theory in the background. I wonder what distance has been created between me and my clients when I have had my attention on the therapy rather than the person in front of me, and about how as Bruscia (2014) and Corey (2011) point out, the quality of relationship can better serve a client than adherence to an idea.

I contemplated the question of how I could best practice inclusively with vocal psychotherapy and somatic experiencing. Recalling the possibility that questioning my competencies may be an outdated habit, I considered what other factors impact my work beyond my level of training. For the first three improvisations I was focused on questioning how well I know the models, singing in improvisation 1, *I have questions, lots of questions, and I have skills that I feel sometimes in possession of and sometimes I don't know where they are*. When reflecting after improvisation 2, I noted, *that was a drastically different experience than the first improv. I was so physically unsettled at the beginning, and I couldn't find a way into the improv for quite a while.* This experience left me with a conscious awareness of how my own dysregulation could be a barrier to attuning with my clients, and a curiosity of whether or not I was succeeding in communicating attunement in the vocal psychotherapy musical space. A fundamental way to help a client stay in the therapy process is for a therapist to share their own regulated nervous system (FHE, 2007). The question of my own regulation became more foundational to addressing my research question as the data analysis progressed. This topic will be further explored in subcategory 2d.

In improvisation 6 I sang, *in the music - the music gives context to the sympathetic charge in my body. It helps me tolerate it, helps me give it a purpose.* This observation was followed with the question, *is* [music] *one of the things that makes it stop – stops it from becoming anxiety?* I was curious whether music can help to contextualize and contain nervous system arousal, and if so, how I would spot it and respond to it within a vocal psychotherapy session. Porges and Rosetti (2018) suggested that music can influence the systems of the body, improving and restoring a client's capacity to regulate, connect socially, and diminish defensive behaviours that might inhibit a return to a healthy state. This position mirrors, to some degree, what I have experienced in my practice. I have also seen how the musical container of a session can keep a client stuck in dysregulation, feeding into a trauma repetition pattern, which is also noted by Austin (2008) and Levine, (1997). I did not have an opportunity within the scope of this study to further investigate this clinical question, but it remains relevant to me to do so.

Subcategory 2b. Clinical needs. In 2015, when I stepped away from my clinical practice to address my burnout, I reflected on my personal philosophy of music therapy

and identified that helping to alleviate suffering was a main motivator for my work. During the intervening years, I've felt that this motivation was no longer enough for me as a therapist, but until now, I had not contemplated or explicitly stated what has been guiding and shaping my work. During data collection I expressed a foundational need to have an updated guiding principle to help contextualize my work, one more specific than the general desire to help and be responsive to clients. In improvisation 1 I asked, *what do I serve? Who do I serve? How do I serve?* In improvisation 2 I identified that sometimes I crave a predictable, generalizable approach to my work, singing, *maybe what's freaking me out is that it's on a case-by-case basis. It's not it's not a rule that I can stick to or a generalization that applies to everybody.[Frustrated noise]. I think I have to be creative. [vocal fry] This is where I am. I've got to be creative [sigh].* My desire for clinical predictability is heavily influenced by my personal wellbeing. At times when I was fatigued or depleted, I wanted a mythical, one-size-fits-all approach to my work. It is the type of rigid thinking that Bruscia (2014) warns us to avoid:

> one-way thinking can prevent therapist and client from being successful in their work, and if this continues for any length of time, burnout is a very real danger. Not only will a therapist risk boredom with his own way of thinking and practicing, he will inevitably encounter many clients and situations that will render him and his work ineffective. Sooner or later, this will undermine his own belief in himself and in music therapy. (p.191)

In my case, one-way thinking was both caused by and the result of burn out. When I am able to be flexible and open-minded enough that, "in that flexibility it is possible to be fixed sometimes, and in that open-mindedness it is possible to be single-minded sometimes" (Bruscia, 2014, p. 187), it is a positive indicator of my personal wellness. When I am feeling resourced and resilient I enjoy the creativity that goes into being responsive to what each client needs from me and how I could respond to those needs. It is no surprise that I identified a need to continually check my thinking for rigidity or inflexibility.

Several needs emerged that impact my personal and professional life. They are included here within clinical needs because they emerged as specifically related to my work. I saw the need to be consciously aware of how much responsibility I attempt to

take on in relationships, which emerged in the subtext of my clinical questions. In improvisation 3 I expressed, *I want to give voice to all the things I was thinking while I worked with you today. So many things ran through my head, but I couldn't say them in the middle of the music. How do I communicate an entire idea to you with no language? With no way to say* [it] *directly to you?* The words talk about communication, but I was expressing the need for control and demonstrating an investment in the idea that spoken communication is more valuable or valid than what is expressed non-verbally while holding space with a client. Further to this realization, I saw that I was invested in the value of my thoughts, assuming they must be shared with the client. I wanted to take responsibility (and control) of the direction of the session and was not staying present to what was happening in the shared musical, non-verbal space. My voice in the therapeutic relationship is important but no more so than witnessing the client as they explore and experiment in the music with new ways of being (Austin, 2008). I would benefit from clinical supervision that helps me to track my countertransference related to the need for control in clinical relationships. As Hahna and Forinash (2019) suggest, I would seek out a supervisor with awareness of the need to provide a balance of support and challenge to help meet my need for emotional safety in professional development.

I voiced my need to find a supportive professional community relevant to my therapeutic approach, and one where there is intellectual, creative, and emotional safety. In improvisation 5 I sang, *I don't know how to do this in a vacuum. I don't know how to figure this out by myself… I want community. I want somewhere safe to be with my questions and my worries and my thoughts without someone telling me I'm not enough. Without someone being uncomfortable with me for what I am. I am enough. I think I am enough.* These comments were influenced by challenging past experiences in some music therapy trainings, making me curious about how holding onto that negative bias against my professional community was contributing to my feelings of professional isolation. I believe that my behaviour was a defensive accommodation, categorized by Kain and Terrell (2018) as intellectualization, my way of using intellect as my defense against experiencing unconscious emotional conflict.

The cross-over point between my desire for community and my tendency to isolate can leave me feeling pushed and pulled without a sense of how to get either need

met. When I sang, *years of challenge and trauma and suffering dulls me down to a broken pencil that cannot write* in improvisation 6, I was speaking about my burnout experience. During data analysis I saw the relationship between these two types of isolation and as Porges (2011) tells us, a traumatized or highly activated nervous system is less available for social interactions. Know this gave me insight into why it has been hard for me to reach out to others in my profession for community.

In improvisation 5 I voiced for the first time that vocal psychotherapy and somatic experiencing may not be enough for me as a clinician. Acknowledging that I want to continue to learn, and by extension, stay flexible in my therapeutic approach directly aligns with Bruscia's (2014) argument for integral thinking. In the audio sample from improvisation 5 (see audio file 7) I explained, *I made an assumption that, that vocal psychotherapy would be the thing for me and then it wasn't enough, it wasn't enough, it wasn't enough. And then one day, there was finally space, and I went off and I learned somatic experiencing and it helped me in so many ways that I decided that vocal psychotherapy plus SE would be the thing I do, the thing that I could bring to the world to offer and to help you. And then sometimes now I realize it's not enough, it's not enough, it doesn't fill every gap and fit every moment – and I want it to. I want it to and the story I told myself was that if I could just become more proficient, better at what I do, then it would be the answer. The answer to that need for meaning {exhale}*. Expressing these thoughts out loud during the improvisation was the first time I could see how invested I was in the idea that a practice of vocal psychotherapy and somatic experiencing would define me as a clinician. I could see how that cognitive bias had led me to doubt myself and my competencies rather than be flexible with my attachment to either model of therapy; a pitfall of one-way thinking, as suggested by Bruscia (2014). Near the end of improvisation 6 I sang, *I made decisions about it at some point, and now I think they've become the truth inside my head instead of just thoughts and curiosities.*

An important clinical need that emerged in the data was to accurately identify my professional development needs. In improvisation 5 I said, *I would like to be better, but really I would like to be calmer*, identifying a new instinctual understanding that my own regulation and embodiment could lead to improved clinical competency. This idea was supported by my acknowledgment in the same improvisation that, *I suspect that I would*

be, all the things I wish I was if I was just – here – a little more often. The repetition of outdated ideas such as *when you speak to me of your life, I worry that I don't have the expertise to help you* (improvisation 3) acted as a cognitive misdirection, keeping me stuck in a personal narrative that pulled my attention away from what would be developmentally useful. In improvisation 5 I sang, *things are gonna change. It's time again for things to change. In fact, they're already changing and what's happening is I'm opting out. I am standing aside and letting the momentum of chaos carry the change.* I was acknowledging that a process of change and growth was happening in my professional development, but I was denying myself an updated perception of my clinical efficacy. Further to this point, with my attention fixed on what was not working in my practice and my professional insecurities, I was not appreciating the normalcy of being a clinician in development, instead falling into doubts about my abilities. Bruscia (2014) reminds us that new ideas can trigger one-way thinking so work may be required for me to stay flexible and open to exploring them, while evaluating how my skill set is evolving. My analysis of the experiential improvisation process reconnected me to the felt knowledge that I have the skills to offer empathetic, supportive, and transformative connections to my clients, and that being regulated will help me access those parts of myself.

Through engaging in self-inquiry, I discovered that I had a need for the research process to give me a tangible outcome, specifically to relieve my discomfort with how to use vocal psychotherapy and somatic experiencing to best effect. In improvisation 2 I said, *I have a bubbly feeling inside in my chest up into my head. Feels like anxiety. I think it's about this improvisation because right before I started I had fear and questions about how this was going to help me. But they weren't really questions, it was more like I had decided this can't help me*. In the same improvisation I sang that the self-inquiry process, *has already helped me*, and I felt relief that it had. I was emotionally invested in a personal outcome of becoming a better therapist. As mentioned in chapter 2, it is Bruscia's (2015) position that in therapy we seek insights as a means to an end and in research the insights are the end. In this study, I produced both, which in my opinion, seems predictable when utilizing for having chosen a self-inquiry methodology.

Perhaps my perception of what it means to become a better therapist broadened while collecting data, because I completed my improvisations feeling unquestionably that I had become a better therapist, despite understanding that my process of self-inquiry felt unfinished. Finding the answers to my questions became secondary to the experience of being curious. I may have foreshadowed this realization in improvisation 1 when I sang, *this many years into my career, I should already know. But what if this is exactly what it's like, you just don't know sometimes or you forget or you lose touch and you have to find your way back.*

Subcategory 2c. Professional values. As a clinician, I need to have clear, professional values, and two of these values emerged in the data collection. The first professional value to emerge was trust. I identified three interwoven trust relationships that felt paramount to focus on: trust in the value of each therapy model, trust in the client to decide the value of the therapeutic experience, and trust in myself as a clinician. Through a combination of improvisation and conversations with my thesis advisor, I came to a realization that I do not fully trust the vocal psychotherapy process. In improvisation 3 I sang, *is it even helping, this music? When you have such concrete problems, is it even helping?* The erosion of my trust may be fueled in part by my burnout experiences, which Bruscia (2015) points out, can lead a therapist to doubts about the efficacy of music therapy and trust in their own abilities. Dileo (2021) writes about the virtues that music therapists need beyond the core competencies of their profession, and she points out that therapists need to trust in their own abilities while also trusting the client's ability to change or grow. Levine (1997) makes a similar point when he writes that the body has the innate ability to recover from trauma when the right conditions are met to help the body access that ability. Psychologically or physiologically, the skillful intervention of the therapist is only part of the process, and the therapist should not try to take responsibility for aspects of health that are the right and responsibility of the client (Bruscia, 2015). To that point, I spoke in improvisation 3 to my clients, singing, *and yet you come back* as a reminder to myself that clients can decide for themselves what the therapeutic process means to them. In fact, the respectful and collaborative nature of vocal psychotherapy is what drew me to practice with it in the first place. Further on in improvisation 3 I sang about trusting myself in my work,

singing, *I know I did some things right, I know that I showed up for you*. Throughout the improvisations I identified sources of my clinical expertise, namely my education, experience with clients, my instincts, my musicality, my creativity, and my ability to attune to clients. I can choose to trust these sources even when experiencing the discomfort of insecurities in my professional competence. For a person to make a conscious shift in where they put their attention is a method of connecting to emotional and psychological resources (FHE, 2007).

In improvisation 6, I compared myself to a friend who is constantly learning and reminded myself that I too, am a curious person. I gave myself the advice to *stay curious* (improvisation 6), noting that my curiosity is more available to me when I am regulated. Further to the understanding that regulation helps me access my curiosity, I identified a previously unconscious value I held – that being calm is a more valuable state than being activated, leading me to wonder when I may avoid heightened emotions in sessions. Levit (2018) points out that psychotherapy is inherently disruptive, and for change to occur there is likely to be discomfort for the client, possibly with intense emotion. A therapist might act to soothe their own anxiety about that intense emotion, missing the opportunity to help a client progress by confusing intense emotion with dysregulation (Levit, 2018). By valuing a restful state over an activated state, I could inadvertently sabotage a client's need for intensity that facilitates personal growth. Bringing this value into my consciousness also made me reflect on how quickly I make meaning of my experiences and whether that action helps me avoid tolerating the unknown.

Subcategory 2d . Challenging professional insights. Through self-inquiry some unconscious beliefs and assumptions I had about my clinical work emerged and were difficult to admit to myself. The most complex, pervasive belief I identified was that having studied them, I am required to use these models in my work, that they must be able to work together, and the fact that I have struggled to use them together means that I am incompetent. In improvisation 1 I started questioning my negative perceptions about my competence and sang, *I think I have a story in my head about all the things that I'm not good at, all the things that I screw up or don't do a good job of and I wonder if that story is accurate. Does it tell the truth?* In improvisation 6 I gained perspective on how my attempts (previous to this study) to integrate the models had not succeeded, and I

realized, y*ou know it never really occurred to me until just right now, but* [my use] *of the models doesn't have to be 100 % of each, all of the time*. I created a goal I could not meet, resulting in my feelings of inadequacy, an experience Dileo (2021) describes as becoming vulnerable to an irrational belief system.

Another challenging insight was the realization that I sometimes experience music as a barrier to connecting with clients, finding that it creates distance rather than connection between us. This experience has led me to question the validity of vocal psychotherapy and my competence as a music therapist. In naming this challenge I saw that a struggle to connect musically with a client does not need to equate to a dismissal of the therapy model or me as a therapist. I had an extreme response, and I believe it to be another version of Bruscia's (2014) one-way thinking, which I struggle with in my clinical life. In my personal musical life, I know that musical experiences can be profound, transformative, and can transcend language. Arguably that knowledge is what led me to become a music therapist. It is uncomfortable and confusing to be 16 years into my career and questioning the solidity of that knowledge.

Subcategory 2e. Inclusivity in clinical ideas. Improvising connected me to my creativity, and I started to see some ways in which the models had commonalities or could positively inform each other. It is an essential part of critical inclusivity to make note not just of the differences between models, but of their commonalities as well (Bruscia, 2014). The relationship between the music of the improvisations and the state of my nervous system showed up in multiple incidences of a connection between tempo and activation, and as well as a connection between musical flexibility and regulation. Essentially, decreasing the music's tempo decreased my level of activation and being less activated gave me access to more musicality and language when improvising. In improvisation 2 I sang, *is there a way for me to observe something in my client that tells me what to do with the music so that I could match* [it] *to what's happening in the client, by altering the tempo - well, more the tempo more than anything else, but the rhythm I guess secondarily - without disrupting a client's sense of safety?* In my clinical experience, a consistent tempo can have a positive or negative influence on the client – something I experienced in this study. In improvisation 2 I noted, *I appreciate the idea of the rhythmic, never changing, hypnotic music pattern, but I don't know, for people who*

are so dysregulated, if it really serves them. I guess I don't know if it's safe to use. My experience with tempo feeds my curiosity of how an intentional tempo change in vocal holding or free associative singing might facilitate access to more unconscious material through increased regulation. I am curious about how I could create opportunities for a wider range of somatic experiences by varying the music's tempo, rhythm, or complexity while maintaining the integrity of the vocal psychotherapy musical framework. In improvisation 2 and 3 I stopped the music completely when I felt overwhelmed and was able to start it again to continue improvising at a slower pace. Finding a way to leave more sonic space at any point in a session might have therapeutic benefits for my clients as it did for me.

Category 3: Insights About My Professional Identity

Insights about my professional identity were defined as realizations that inform how I think about and how I present myself as a professional.

Subcategory 3a. Realizations about my professional identity. A core theme that emerged in the data was linked to my professional identity, and the confusion I feel about what that identity is now that I have pursued specialized trainings beyond my undergraduate music therapy training. Prior to designing this study, I was focused on the idea that to practice in a coherent manner, I needed to find a way to integrate vocal psychotherapy and somatic experiencing. I had found small ways to integrate them but saw more differences than similarities. My thesis advisor suggested thinking about inclusivity rather than integration and this shift in perception opened a viable pathway to investigate my clinical experiences. Initially, even inclusivity felt out of reach because I was so focused on the differences between the models which I perceived as incompatibilities. In the first improvisation I sang, *I want to be comfortable in between, but if I'm always in between then what do I anchor to?* I can see now that I was expecting a model of therapy to be my foundation, rather than, as Bruscia (2014) recommends, applying a flexible mindset to therapy and using the client relationship as the foundation. Each skill set I study influences and changes the others; Bruscia (2014) said that we should welcome these changes but at the same time be able to maintain a clear distinction between the concepts of each model.

Subcategory 3b. A foundation of fluidity. Dileo (2021) suggests that a therapist should not just follow ethical rules but should cultivate virtues such as caring, humility, empathy, courage, and prudence to be a comprehensive professional. When listening to my improvisations I could hear how my virtues had become unbalanced – how an overabundance of caution was causing me emotional distress. In improvisation 4, directly after imaging about skating on thin ice I sang, *I feel like I exist in a fraction of who I am. A narrow little field with not a lot of room to move. Held, bound even. And it holds me. I suppose it's a type of safety, but it's not effortless. It takes quite a lot of who I am to maintain this space*. The imagery metaphor of existing on a thin surface led to my insight that existing in a dysregulated state is taxing for my physiology, and while at one time it may have been an effective way for me to manage stress, it had become dissatisfying. Kain and Terrell (2018) explain that this type of maladaptive physiological response can develop with chronic exposure to stress. It is possible that a better balance of virtues could ease my sense of being bound. There is a parallel between the image of being bound and my difficulty in accessing fluidity in my clinical work. Bruscia (2015) names fluidity as a music therapy competency that must be actively developed, and that music is the space in which to develop it. The combined understanding of these two points led me to the idea that what I crave as a foundation of my practice does not stem from my comprehension of my profession, but from a physiological grounding that allows me access to who I am and what I know within a fluid framework as I respond to my clients' needs.

Subcategory 3c. An evolving professional identity. Participating in this self-inquiry did not provide the clarity I sought about my professional identity. There is more exploration needed for me to get clear on what it means to me to be both a music therapist and a somatic experiencing practitioner. The concept of critical inclusivity make sense to me, in particular, finding the commonalities and differences between the models I use in my practice. What I suspect I need most is further development of my integral thinking skills. The one-way thinking I identified in improvisation 6 (previously mentioned in subcategory 2c) is an example of the rigidity in my thoughts that I want to soften. Integral thinking is a mindset that accepts differences as key to growth (Bruscia, 2014). I believe that my mindset began to shift during the research process because I

started seeing more commonalities between the models and had ideas and curiosities about the ways in which they have influenced each other in my practice. I had an insightful moment in improvisation 3 about letting go of the titles that come along with the specialized trainings and even taking a break from using the related techniques, singing, *what if did something else, tried something else?* Feeling bound by my professional designation is another link to the one-way thinking I am unravelling in my professional identity.

Chapter 5. Discussion

The final phase of Moustakas's (1990) heuristic methodology is the creative synthesis, a creative act that represents the evolution in the researcher's relationship to the material being examined. Through creative synthesis, the problem may remain, but for the researcher, "an internal bodily shift has occurred" (Moustakas, 1990, p.123) allowing for a new perspective to have been gained. The design and rationale for the creative synthesis are presented here along with the accompanying audio file (see ???). Chapter 5 also includes the limitations of the study, a presentation of a range of implications resulting from the research process and results, and my concluding remarks.

Creative Synthesis

Moustakas (1990) writes that a creative synthesis, "brings together the relevant factors of ambition, hope, expectancy, distortion, and denial and points the way to a new vision and plan of action" (Applications of Heuristic Research, p. 25, part 5). When reflecting upon how to approach the creative synthesis for this study, I decided to design a creative act that embodied the concept of a new vision. After identifying the moments in the improvisations that seemed to best reflect the most salient insights, I realized that these excerpts also seemed to represent a synthesis of how I would like to move forward to integrate the knowledge I gained from this research process. I layered the excerpts together, creating a collage of sounds. The collage starts with 0:37 of instrumental piano taken from a portion of the accompaniment recording from improvisation 5. I named this sample 'a friendly sound' because my first words in improvisation 5 were, s*uch a friendly sound… Sweet. Sweet and comforting*. The first verbal excerpts then fades in and becomes the repeating foundation upon which the other audio excerpts are layered until the end of the collage at 4:40. The audio excerpts included the following nine verbalizations:

1. *I would like to be better, but really I would like to be calmer, calmer* (from improvisation 5)
2. *I am enough* (from improvisation 5)
3. *Underneath, underneath the ice there's dark but there is also life, and depth* (from improvisation 4)
4. *Each tiny moment, just as important as the last one* (from improvisation 4)

5. *I wanted you to know that you are not alone. I wanted you to feel me there.* (from improvisation 3)
6. *I suspect that I would be, all of things I wish I was if I was just here a little more often* (from improvisation 5)
7. *Each tiny moment, just as important as the last one. Each tiny moment is as important as the last one. Not just the moment, not just the moment when things begin… not just the moment when things begin… not just the moment when things begin… begin… not just the moment when things begin… not just the moment when things begin* (from improvisation 4)
8. *I'd like to understand better how to be in between… in between* (from improvisation 5)
9. *Stay curious* (from improvisation 6)

During the creation of the collage, I added the excerpts one at a time and spaced them out to create auditory definition. This definition gave me the auditory space I need (as discussed in chapter 4) to hear and reflect on the content of each sample in a way that feels meaningful to me. Some excerpts were repeated and some feature once in the recording. These creative decisions about sample placement were made spontaneously but purposefully, to reflect the improvisational nature of this study's method and my intentional engagement with the insights I gained from the research process. The layered audio excerpts came from improvisations in a variety of keys, resulting in complex sounds, sometimes clashing, sometimes surprisingly compatible. Listening to the collage brought the concept of critical inclusivity to my mind, as the collage was held together by one repeating excerpt that was long enough and spacious enough to act as a foundation for the others. The excerpt was repeated continuously (or *looped*); this loop contains what I experienced to be the most profound insight from this study – the possibility that supporting my nervous system could shift my perspective on all of my other questions and beliefs. It was the moment my mindset eased its grip on the idea that I am not enough as a clinician. When the other excerpts clashed, or started and stopped abruptly, there was enough consistency in the foundational loop to absorb the differences. I heard the clashes as moments of interest that made the collage richer. Hearing the collage as a metaphor for

an inclusive mindset left me feeling creatively engaged, and hopeful about the continued evolution of my therapy practice (see audio file 8).

Limitations

It is important to acknowledge the limitations that impacted and shaped this research process. This study was limited by the scope and predetermined timeline of a master's thesis process. The study could also have been limited by my pre-existing cognitive bias of incompatibility between the therapy models in my practice. The amount of time I designated for the explication phase of the methodology needed to be extended because the process of analyzing my data and making meaning of my experiences took longer than I anticipated. Completing this study during the COVID-19 pandemic limited my options for location, opportunities for and availability of peer support, as well as the challenging emotional impact of being a front line mental health worker during a time of societal distress.

Implications from the Research

Personal implications. This self-inquiry made it clear to me that I need to pursue more self-care in the form of regulation. I intend to continue an experiential self-inquiry practice, emphasizing the spaciousness that benefitted me during this study. Improvisation has not been a musical form I have gravitated towards recently (outside of clinical settings), and it was a valuable experience to return to it. I will make personal creativity a priority, and as pandemic restrictions allow, I will engage in other people's art, such as theater and concerts. I will continue to pursue personal therapy as it has been a valuable resource in my life and consider expanding that practice to include music psychotherapy.

The choice to combine elements of vocal psychotherapy and somatic experiencing resulted in some valuable insights for me with which I can move forward. Within the context of this study, I think combining the models worked well. I have not yet fully explored what it means to be a critically inclusive practitioner, but the insights gained through this study were an informative place to start as I continue to look for answers. I'd like to use the models separately to investigate my research question, but with the support of a trained practitioner in each one, so that I can get the full benefit of what each model

offers. This approach might be best suited to personal therapy before potentially being adapted as part of clinical supervision or as a research methodology.

Clinical implications. This study situates an individual self-inquiry in the larger framework of the benefits of reflexivity. My intention in revealing my experiences was to demonstrate the value of reflexivity to my professional community, with the hopes that other music therapists will pursue a similar process to refine and improve the quality of their work.

This thesis was written during the COVID-19 pandemic and the accumulative effects of ongoing isolation made my need for professional community even more necessary. Isolation became a habit for me, so seeking regular clinical supervision would be wise to help to address that isolation as well as my clinical practice challenges. As I mentioned in chapter 4, supervision with a balanced approach between support and challenge would suit my learning needs. Although I have not yet found a supervisor who practices in the same models as I do, I have not exhausted every avenue to find someone compatible with my needs. Being more visible with the work I do might connect me with other likeminded music therapists, and I enjoy speaking at conferences and teaching in my field. More regular peer supervision is also an option, to support me as I clarify my current professional identity (Dileo, 2021). Based on the volume and quality of the insights that emerged from this study, continued reflexivity would be a valuable asset in my clinical life, and it could help me develop a more intentional style of self-supervision (Bruscia, 2015). Completing this study has also reinforced for me the importance of keeping current on music therapy research. Staying abreast with current publications would be another way of staying connected to the music therapy community and would give me more opportunity to revisit the theoretical foundations of my practice.

As I mentioned in chapter 4 (subcategory 2a), I did not have an opportunity within the scope of this research to investigate my experiences of how the musical container of a session can keep a client stuck in dysregulation, seemingly feeding into a trauma repetition pattern. More literature has been published since I completed my data collection that may be relevant to my experiences, including Flynn's (2021) presentation of three clinical vignettes about the use of vocal psychotherapy for bereaved adults with attachment trauma, during which she worked from a somatic perspective so as to avoid

overwhelming her clients' nervous systems. In her analysis of the vignettes, Flynn (2021) identified that by working intentionally and pacing her interventions appropriately for each client's tolerance, vocal psychotherapy facilitated reparative experiences for her clients. While Flynn's vignettes differ somewhat from my clinical experiences and do not address the specific questions I have about inclusivity, it is inspiring to read about vocal psychotherapy processes contextualized in a somatic framework.

Professional identity implications. The implications for my professional identity continue to unfold and were not conclusive over the duration of this study. My goal is to feel more coherence in my perception of my practice, aiming for a cooperative, congruent, self-regulating system (FHE, 2007) where I am accessing my knowledge from a foundation of my empathetic, attentive presence. Other music therapists with specialized trainings may experience similar confusion about their professional identities and engaging in reflexivity may offer them perspective on that confusion.

Education and training implications. There is a considerable role for reflexivity in music therapy training programs, and it is especially helpful in connecting theory to practice (Barry & O'Callaghan, 2014). It is essential to learn experientially when working with music, an experiential modality (Bruscia, 1998; 2015). Self-inquiry gives students a chance to explore themselves, and to be conscious of what they bring into their therapeutic relationships (Bruscia, 2015).

Research implications. This research design generated a great deal of data, and the complexity of analyzing this volume was a challenge for me as a first-time researcher. The data set could be re-interpreted a variety of ways, and I may take the opportunity to refine my interpretations should I decide to work toward a publication of this study. A follow up study (i.e., part two) could investigate the relationship between vocal quality and verbal content with an examination of the musical elements, vocal qualities, a chronological mapping of the content of the six improvisations.

It is my hope that by sharing my experience with reflective and experiential self-inquiry, other creative arts therapists may see how a reflexive practice can create personal and clinical momentum around the challenging aspects of our work.

Concluding Remarks

When embarking on this research journey, I was focused on the hope that the research would reveal something new to me that would help me to be a better therapist. As I bring the project to a close, I appreciate that the process generated wealth of personal and clinical insights while connecting me to what I already knew. During the coding process, a lot of familiar language came up in the themes that emerged. It struck me that throughout my adult life I have written songs about many of these themes – safety, time, needing to not be so isolated in my experience. Perhaps the insights gained through this study were not so much new as a reconnection to what had been hidden, moving facets of my knowledge from unconscious to conscious. Throughout this transition, I was connected to my tacit knowledge about the personal, clinical and professional and created stronger, clearer relationships to that knowledge. It was humbling to go through this process and vulnerable to write about it, but the conclusion I experienced was edifying, and for all of the vulnerability, I feel stronger, both as a person and a therapist. I was once told that when undertaking hard work, I could choose to do it joyfully. The journey through this reflective and experiential self-inquiry had many difficult moments, but the impression that remains for me is the joy of discovery.

References

Ahonen, H. (2017). Adult trauma work in music therapy. In J. Edwards (Ed.). *The Oxford handbook of music therapy*. Oxford University Press.

Austin, D. (2002). The voice of trauma: A wounded healer's perspective. In J.P. Sutton (Ed.), *Music, music therapy and trauma: International perspectives* (pp. 231-259). Jessica Kingsley.

Austin, D. (2008). *The theory and practice of vocal psychotherapy: Songs of the self*. Jessica Kingsley.

Barry, P. & O'Callaghan, C. (2014). Reflexive journal writing: A tool for music therapy student clinical practice development. In. Bruscia, K.E. (ed.). *Self-experiences in music therapy education, training, and supervision.* Barcelona. (Reprinted from *Nordic Journal of Music Therapy*, *17*(1), 55-66.)

Bell, S.A. (2018) A music therapist's self-reflection on her Indigenous heritage: A heuristic self-inquiry. *Canadian Journal of Music Therapy*. 24, 58-75.

Bosco F. (2010) Translating somatic experiencing and gestalt therapy for trauma resolution into music therapy practice with adults. In Stewart, Kristen, ed. *Music therapy & trauma: Bridging theory and clinical practice*. Satchnote Press; 58-73.

Brom, D., Stokar, Y., Lawi, C., Nuriel-Porat, V., Ziv, Y., Lerner, K., & Ross, G. (2017). Somatic Experiencing for Posttraumatic Stress Disorder: A Randomized Controlled Outcome Study. *Journal of Traumatic Stress*, *30*(3), 304–312.

Bruscia, K.E. (1998). Techniques for uncovering and working with countertransference. In K.E. Bruscia (Ed.) *The dynamics of music psychotherapy* (pp.93-120). Barcelona.

Bruscia, K.E. (2014). *Defining music therapy.* (3rd ed.). Barcelona.

Bruscia, K.E. (2015). *Forms of reflexivity in music therapy: An anthology*. Barcelona.

Canadian Association of Music Therapy. (n.d.) *About Music Therapy*. Retrieved April 10, 2021, from https://www.musictherapy.ca/about-camt-music-therapy/about-music-therapy/

Canadian Counselling and Psychotherapy Association. (2022). *British Columbia regulation.* Retrieved March 19, 2022, from https://www.ccpa-accp.ca/british-columbia-regulation/

Corey, G. (2011). *Theory & Practice of Counseling and Psychotherapy* (Seventh Edition). Nelson Education Ltd.

Dileo, C. (2021). *Ethical thinking in music therapy.* Jeffery Books.

Douglass, B. G., & Moustakas, C. (1985). Heuristic inquiry: The internal search to know. *Journal of Humanistic Psychology*. https://doi.org/10.1177/0022167885253004

Flynn, C. (2021). A somatic approach to vocal psychotherapy for bereaved adults with attachment trauma. *The Arts in Psychotherapy*, *76*, 101858. https://doi.org/10.1016/j.aip.2021.101858

Foundation for Human Enrichment. (2007). *Somatic experiencing: Healing trauma*. Training manual.

Ghetti, C.M., & Keith, D.R. (2016). Qualitative content analysis. In Wheeler & Murphy (Eds.) *Music therapy research (Third)*. Barcelona.

Hanha, N. & Forinash, M. (2019). Feminist approaches to supervision. In M. Forinash (Ed.), *Music therapy supervision (2nd edition).* Barcelona.

Harris, D. A. (2009). The paradox of expressing speechless terror: Ritual liminality in the creative arts therapies' treatment of posttraumatic distress. *The Arts in Psychotherapy*, *36*(2), 94–104. https://doi.org/10.1016/j.aip.2009.01.006

Harris, M., Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, *89*, 3–22. https://doi.org/10.1002/yd.23320018903

Iliya, Y.A., & Harris, B. T. (2016). Singing an imaginal dialogue: a qualitative examination of a bereavement intervention with creative arts therapists. *Nordic Journal of Music Therapy*, *25*(3), 248-272. http://dx.doi.org/10.1080/08098131.2015.1044259

Kain, K., & Terrell, S. (2018). *Nurturing resilience*. North Atlantic Books.

Kuhfuss, M., Maldei, T., Hetmanek, A., & Baumann, N. (2021) Somatic experiencing – effectiveness and key factors of a body-oriented trauma therapy: a scoping literature review. *European Journal of Psychotraumatology*. *12*(1929023). https://doi.org/10.1080/20008198.2021.1929023

La Roche, P. (2021). *A music therapist's exploration of vocal improvisation for self-care: A heuristic self-inquiry.* [Master's thesis, Concordia University].

Lee, J. H. (2015). Integral Thinking in Music Therapy. *Journal of Music and Human Behavior*, *12*, 65–94. https://www.researchgate.net/publication/278329279

Leitch, M. L., Vanslyke, J., & Allen, M. (2009). Somatic experiencing treatment with social service workers following hurricanes Katrina and Rita. *Social Work*, *54*(1), 9–18. https://doi.org/10.1093/sw/54.1.9

Levine, P. A. (1997). *Waking the tiger: Healing trauma : the innate capacity to transform overwhelming experiences*. North Atlantic Books.

Levine, P.A. (2007) Trauma, rhythm, contact, and flow. In J. Loewy (Ed.). *Caring for the caregiver: The use of music and music therapy in grief and trauma* (pp. 148-153). American Therapy Association.

Levine, P. A., Blakeslee, A. M., & Sylvae, J. (2018). Reintegrating fragmentation of the primitive self: Discussion of "Somatic Experiencing." *Psychoanalytic Dialogues*, *28*(5), 620–628. https://doi.org/10.1080/10481885.2018.1506216

Levit, D. (2018). Somatic experiencing: In the realms of trauma and dissociation - What we can do, when what we do, is really not good enough. *Psychoanalytic Dialogues*, *28*(5), 586–601. https://doi.org/10.1080/10481885.2018.1506225

McFerran, K. (2010). *Adolescents, music, and music therapy: methods and techniques for clinicians, educators, and students.* Jessica Kingsley.

McGraw Hunt, A. (2016). First person research. In Wheeler & Murphy (Eds.) *Music therapy research (Third)*. Barcelona.

Merriam-Webster (n.d.). Insight. In *Merriam-Webster.com dictionary.* Retrieved March 19, 2022, from https://www.merriam-webster.com/dictionary/insight

Moran, D. (2018). Mindfulness and the music therapist: An approach to self-care. *Qualitative Inquiries in Music* Therapy, *13*, monograph 3. D. Keith (ed.). ISSN: 1559-7326.

Moustakas, C. (1990). *Heuristic research: Design, methodology, and applications*. SAGE Publications. https://doi.org/10.4135/9781412995641

Porges, S. W. (2011). *The polyvagal theory : Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. W.W. Norton.

Porges, S. W., & Rosetti, A. (2018). Music, music therapy and trauma. *Music & Medicine. 10*(3), 117-120. https://doi.org/10.47513/mmd.v10i3.635

Somatic Experiencing International. (n.d.). *Program Descriptions*. Retrieved April 13, 2021, from https://traumahealing.org/learn-se/

Sultan, N. (2019). *Heuristic inquiry: Researching human experience holistically*. SAGE , https://dx.doi.org/10.4135/9781071802632

Sutton, J. P. (2002). Trauma: Trauma in context. In J.P. Sutton (Ed.), *Music, music therapy and trauma: International perspectives* (pp. 21-39). Jessica Kingsley.

Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

Wheeler, B. L. (2015). Music therapy as a profession. In B.L. Wheeler (Ed.), *Music Therapy Handbook*. Guilford Publications. http://ebookcentral.proquest.com/lib/concordia-ebooks/detail.action?docID=1760730

Wigram, T., Pedersen, I.N., & Bonde, L.O. (2002). *A comprehensive guide to music therapy*. Jessica Kingsley.

Winblad, N. E., Changaris, M., & Stein, P. K. (2018). Effect of Somatic Experiencing Resiliency-Based Trauma Treatment Training on Quality of Life and Psychological Health as Potential Markers of Resilience in Treating Professionals. *Frontiers in Neuroscience*, *12*. https://doi.org/10.3389/fnins.2018.00070

Yachi, C. T., Hitomi, T., & Yamaguchi, H. (2018). Two experiments on the psychological and physiological effects of touching-effect of touching on the HPA axis-related parts of the body on both healthy and traumatized experiment participants. *Behavioral Sciences*, *8*(10), 95.

Zarate, R. (2015). Clinical improvisation and its effect on anxiety: A multiple single subject design. *The Arts in Psychotherapy*. *48*, 46-53.