

CURRENT PRACTICES IN NORDOFF-ROBBINS MUSIC THERAPY (NRMT):

THE VIEWS OF CONTEMPORARY PRACTITIONERS IN 2011

A Dissertation

Submitted to

the Temple University Graduate Board

in Partial Fulfillment

of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

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May, 2012

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ABSTRACT

The purpose of this study is to describe current practices in Nordoff-Robbins Music Therapy (NRMT) practice as perceived by contemporary practitioners in 2011 compared with the original approach as developed by its founders. I did this by interviewing prominent Nordoff-Robbins music therapists, and asking them how their way of practicing compared to how they believed Nordoff and Robbins originally practiced the model. I then transcribed and analyzed their responses to the interview questions, looking for themes of commonality and difference in their responses.

ACKNOWLEDGMENTS

I would like to thank my dissertation committee: Drs. Kenneth Bruscia, Darlene Brooks, and Cynthia Folio for graciously agreeing to be on my committee and for offering your expertise, time, and attention to detail. To Dr. Kenneth Bruscia, my committee Chair, advisor, and gracious mentor, I thank you for always being available, supportive, encouraging, and always ready to guide. You have showed me new and deeper ways to read, write, think, and in the end, to understand. Without your guidance and persistent help this dissertation would not have been possible. To my dear Jillian, thank you for your patience, your talent, and the gift of your time in helping me through what turned out to be a major project.

DEDICATION

This dissertation is dedicated to Dr. Clive Robbins (1927-2011). I dedicate it to the man, who did not live to see it completed, and to his work, which permeates every word of it, and lives on.

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CHAPTER ONE:
NORDOFF-ROBBINS MUSIC THERAPY AS ORIGINALLY CONCEIVED

Purpose of Chapter

The purpose of this chapter is to review how the founders of NRMT articulated the approach they developed. This can prove to be a difficult task considering the value they placed on creative flexibility outweighing a need to establish a potentially limiting, prescriptive methodology. Constructing a definition for an approach that the founders themselves did not definitively articulate, requires an examination of the work they produced in the form of case studies, descriptions of clinical interventions, and techniques with specific clients in an effort to establish credible commonalities.

Definition of NRMT

Although there are many models of improvisational music therapy, one of the most widely used was developed by Paul Nordoff and Clive Robbins between 1959 and 1974. This approach became known as “Creative Music Therapy,” after the title of their book by the same name (1977). The approach is “creative” in that the therapist creates music that is used as the therapeutic medium as each intervention evolves.

NRMT is rooted in the belief that every human being has the potential to respond to music regardless of adverse conditions, challenges, or illness. This potential is called “the music child.” The music child is “the individualized musicality inborn in every child: the term has reference to the universality of human musical sensitivity—the heritage of complex and subtle sensitivity to the ordering and relationship of tonal and rhythmic movement—and to the uniquely personal significance of each child’s musical

responsiveness” (Nordoff & Robbins, 1977). The use of the term music “child” may have evolved as a result of the particular populations with whom they exclusively worked.

Clinical Populations and Goals

From their first meeting at the Sunfield Children’s Homes in England in 1958, the exclusive focus of the clinical work of Nordoff and Robbins was on what are now termed “children with special needs.” The founders believed that the therapy inherent in music could have a far-reaching effect upon the development of children who “bear the handicaps of mental impairment, emotional disturbance or physical disability” (Nordoff & Robbins, 1971). Although their clients were all children, Nordoff and Robbins believed that effective therapy was not limited by the child’s pathology, age, social and economic background, and could potentially be undertaken in all conditions of special education and institutional or clinical care.

Keeping with the creative spirit of the approach, Nordoff and Robbins constructed therapeutic goals based on the individualized needs, capabilities, and potentials of each client. Goal areas might include: the enhancement of expressive freedom, an increase in capacity for spontaneous communication, greater musical flexibility and relatedness, decreased pathological behavior patterns, and the further development of interpersonal relationships, socialization skills, language, and self-confidence. Goals become more individualized as the course of therapy unfolds, based on the client’s responses to specific music. In NRMT, the acquisition of musical skills, such as learning how to play the clarinet, is considered a by-product of the musical interventions; the primary aim is the ever-widening range of the client’s musical experiences that address cognitive, expressive, motoric, and social deficits. Musical goals may include increasing the range

and flexibility of tempo and dynamics, establishing the ability to anticipate forms implicit in the musical structures employed, and increasing the ability to listen and respond to the musical ideas communicated by others. These goals lead to refinements and further development in motor planning, responsiveness to auditory cuing, fine and gross motor skills, visual-spatial processing, and sensory modulation. Although their clients were all children, effective therapy was not limited by the child's pathology, age, social and economic background, and could potentially be undertaken in all conditions of special education and institutional or clinical care.

Individual versus Group Therapy

It is interesting to note that the first collaborative efforts of Nordoff and Robbins involved work in group therapy. Their partnership began in 1959 with their collaboration on what they called a "working game," based on the story of Pif-Paf-Poltrie, a Brothers Grimm folk tale. Music for group therapy was developed to accompany stories that could educate and provide the framework for the development of social skills and emotional exploration. Group therapy may be indicated for children who could benefit from peer modeling, who may not be ready for the intensity of focus that accompanies individual work, or for children who have achieved some of the goals established in individual therapy and are ready to take on some demands that come with the acquisition of social skills inherent to group work.

The individual work of Nordoff and Robbins began later using improvised music as a means of making contact with children who were often otherwise unreachable or nonresponsive. Work with individual children focused on rhythmic organization, variations of tempo, and antiphonal rhythmic response became fundamental components

of individual work. An example of this work can be seen in the case of David (a pseudonym used in the first publication of the case study, and whose actual name, Charlie, appears in *Creative Music Therapy* (2nd Edition)). After nine months of concerted effort, Charlie had not been able to acquire the skill of tying his shoes. However, when the process was contextualized in a song, Charlie succeeded in his second attempt. This is the boy for whom the song, “Charlie Knows How to Beat That Drum” was spontaneously created when he succeeded in gaining control over the instability of his drum beating. The theory behind the percussive work with David stemmed from the belief that as the ability to organize his drum beating developed, it would stimulate parallel growth and development in other areas of his inner life. Children who are challenged to relate to the therapist or to the music, or who have not yet reached a stage of development that enables them to work with peers, are referred to individual therapy sessions in which the therapy team can tailor every intervention to fit the individual needs of the child in the moment.

Roles of Therapist and Co-Therapist

In its original conceptualization, NRMT involved two therapists participating in sessions. The primary therapist, Nordoff, was responsible for spontaneously creating music on the piano, while the co-therapist, (referred to at the time as an “assistant”) Robbins, physically facilitated the child’s musical participation, sustained focus, and engagement. In 1998, Robbins reflected on his role: “I was a facilitator. I made the physical conditions right. I facilitated the child toward the music therapist, and at times when I felt the child needed to go more into the music, I facilitated that” (Robbins, 1998). While serving in the Royal Air Force during World War II, Robbins sustained a serious

gunshot injury leaving him partially paralyzed in the left hand and arm. He was discharged from the RAF and spent the next several years recuperating physically and psychologically from his ordeal in the service. He eventually found his way to Sunfield Children's Home where he trained as a teacher and where he eventually met Paul Nordoff. Although the dynamics of a particular team may vary from another, traditionally "the role of the pianist is to engage the child musically in a developmentally effective way, while the role of the assistant is to support the pianist's work, to supplement it resourcefully in whatever way the situation calls for" (Nordoff & Robbins, 1971).

The roles of the therapists within the original clinical team varied depending on whether the team was working with an individual or a group. Generally, Robbins, "on the floor" in a group, was responsible for the direction of the interventions, while Nordoff provided a musical framework to support his partner's clinical direction. In individual therapy sessions, Robbins functioned to redirect the child's focus to the music and facilitate physical participation—in short: doing what was needed to maximize the child's engagement in the musical experience.

Originally, the co-therapist worked attentively and empathically alongside the primary therapist within the creative process. The purpose of the co-therapist was to provide support that would best facilitate the child's participation in the therapeutic experience. The clinical situation may call for the co-therapist to function as guide, encouraging presence, role model, instrumental player, singer, or dancer. Generally, the role of the co-therapist is to be supportive and attentive at every moment to how the primary therapist is working and to the child's responses. Even during moments of apparent inactivity, the co-therapist must remain completely attentive to the course of the

session. For example, the co-therapist's rapt and engaged focus on the music during a group session, encourages the redirection of potentially otherwise distracted clients, much in the way that a person staring intently at the sky causes those nearby to turn their heads in interest.

It is significant to note that Paul Nordoff never saw a client by himself. Nordoff's choice to consistently work as part of a team implies that he was aware of the increase in the number of possibilities inherent in utilizing a co-therapist. Virtually all of the literature produced by the founders, describe work undertaken as a team. The advantages of working within a team approach were, "musical, procedural, psychological, and practical" (Nordoff & Robbins, 2007). In addition to the practical advantages (i.e., the ability to manage client behaviors that may divert focus from the ongoing music) the co-therapist can also serve as a model of musical participation by playing an instrument or singing, as an active listener engaged in the music, or as a participant with any degree of active participation between the two. Even though sometimes undetectable on audio tape, Nordoff and Robbins considered the co-therapist's presence as always impacting the unfolding creative process.

Nordoff and Robbins not only functioned as a clinical team, but also collaborated on composing music used in the sessions, publishing books and articles about their work, presenting their work in professional settings, and training music therapy students to carry on the work in future generations of practice.

Therapist-Client Relationship

The primary focus of interaction in NRMT is on "the music created by the client(s) and therapist(s) and on the relationships that ensue" (Nordoff & Robbins, 1977).

In the original approach, therapists improvised “music based on the client’s musical and non-musical responses, reactions, and expressions, with the main aim of developing a musical relationship” (Nordoff & Robbins, 1977). Verbal discussion was not viewed as essential while significance was placed on the musical experience and level of musical relatedness of the client and the therapist. The therapist’s primary concern was to develop and incorporate musical interventions that deepened the client’s musical engagement and interaction. The improvised music was individualized for each child, as the therapist at the piano responded musically to any and all salient aspects of the client’s presence: bearing, facial expression, glance, movements, mood, etc. The aim was to communicate with spontaneity and immediacy. An example of the way in which Nordoff did this can be seen in the case study of Edward, a 5-year old boy whose habitual response to the world around him was to reject it, scream, and cry. The therapists provided a musical-emotional environment for Edward, matching and meeting his screaming and crying through musical improvisation. Music began to bring Edward’s isolating emotional tantrums into two-way communication. As his vocal responses became more musically related to the therapist’s with regard to pitch, rhythm, and melodic patterns, his sense of self and others was enhanced. Nordoff and Robbins discovered that clinical improvisation functioned as a mirror which enabled Edward to deepen his awareness of self and those around him. This significant achievement became the foundation for the development of interpersonal relationships for Edward.

Nordoff and Robbins viewed and measured progress in a course of therapy by the development of the client-therapist relationship in musical activity. Stages of relational development were detailed in Assessment Scale I: Child-Therapist Relationship in

Coactive Musical Experience. The criteria of this assessment scale included indications of the evolution of the child's "awareness, state of mind, or quality of affect in relation to the therapy situation" (Nordoff & Robbins, 2007). Participation at the lowest levels of the scale might include unwillingness to participate or distress. Levels of heightened musical participation indicate a deepening relationship between therapist and client. This may be reflected by flexibility and mutual awareness in the coactive music-making experience. To Nordoff and Robbins qualities of resistiveness also came to be understood as components to be acknowledged and appreciated as a part of the developing relationship. These qualities of resistiveness were thoroughly discussed and included alongside aspects of participation in the Relationship Scale I.

Improvisational Strategies

Improvising in music therapy is composing in the moment. As a musician taking on the responsibility of a therapist, the founders approached clinical music with the seriousness and intention of a performer. In 1977, Nordoff and Robbins attributed the power of music in therapy to the therapist's communicative, musical intent.

When improvising, Nordoff incorporated the strategic use of mobility of pulse and tempo in order to more freely capture fleeting changes in client activity. Experimental accompaniment of any rhythmic movement a child might make (jumping, rocking, hand flapping, finger movements, etc.) with appropriate reflection of articulation and mood and tempo can work as a means of establishing active contact. The child might modify his movements in response to changes in the music, or a musically inactive child unwittingly might make the first steps into coactive, relational music-making, evoked by the music itself rather than in what might be viewed as conscious choice of behavior.

Pianistic devices utilized by Nordoff in improvisations included: restraint in pedaling, for the purpose of creating clear melodic tones and shifts in harmony; detached playing, in order to emphasize intervallic relationships; the use of touch and texture, touch being an effective tool in directing or containing the client, while texture involves degree of exposure. Nordoff was aware of what might appear to be a minute musical detail, and used these compositional elements flexibly and purposefully.

Well-versed in the art of accompanying, Nordoff was acutely aware of the relationship between piano and voice. Nordoff was adept at providing containment at the piano, offering support to the voice, whether it was his own or a client's. During moments that did not emphasize the voice, Nordoff could then assume a directive, even confrontational role at the piano. This balance allowed fluidity as Nordoff alternately functioned as both director and supporter.

Nordoff and Robbins saw the client as an active creator of music, playing a vital role in the direction of the musical process, singing and playing various instruments that require no formal training or experience, while the therapist improvises music that enhances and shapes the client's music-making, emotional state, and/or movements—all with the aim of promoting relatedness, communication, socialization, and awareness within the music itself. The therapist may: create a musical scenario that seeks a musical response; create music that reflects a client's "being" or emotionality; or improvise music to address the client's sensory needs for musical engagement. Furthermore, the therapist may create music that seeks to provoke a client into a certain musical response, or improvise music that reflects a client's idiosyncratic, perseverative behaviors in order to make the behaviors more communicative and interactive. In all forms of NRMT, the

therapist uses his or her musicianship, creativity, intuition, and clinical knowledge of the child to improvise music that will activate the client's will, motivation, and passions, thereby bringing the client into musical mutuality and intentionality. Emphasis is given to the musical relationship between the client and therapist.

The founders maintained that there is no formula or set of principles that can lead a therapist to a clear choice of music. The practical answer comes from the therapist's observations of the child's presence, personality, condition, needs and activities, and from the totality of the therapist's musical biography. Improvisations in many styles can be based on pre-composed works by choosing themes, phrases, rhythms, and moods, extending this material freely and expressively. Over time, the therapists and client together develop various musical materials (e.g., themes, songs, and instrumental pieces), based on spontaneous events and experiences that arise in each session. Within these co-created musical materials, clinical goals and treatment plans are identified and pursued by the therapists. It is worth noting that, although verbal communication (speech) is not a requisite component of the NRMT approach, the use of songs with lyrics, both pre-composed and improvised, has been integral to the approach since its beginnings.

Theoretical Foundations

Nordoff and Robbins shared a common interest in the Anthroposophical teachings and writings of Rudolph Steiner. One concept that had particular significance for the founders dealt with the intervallic relationship of tones. This relationship encompassed movement, stability, balance or imbalance, tension, consonance, and resolution. Every tonal intervallic relationship took on meaning and represented an emotional state of being. This belief made every note played a spiritual experience, and placed immense

value on every detail and musical choice made in the clinical encounter. Additionally, the tonal and intervallic relationships between the client's evoked responses and the therapist's music was thought to have significance on multiple levels.

The work of Abraham Maslow contains parallels to the work of Nordoff and Robbins. For example, Maslow's hierarchy of human needs, the fulfillment of which enabling the individual to achieve a state self-actualization, corresponds to the Levels of Participation and Resistiveness as articulated in Nordoff and Robbins' Client-Therapists Relationship in Musical Activity Scale I. Robbins asserts that when he discovered Maslow's work, "it was like a hand in the glove. It was a fit. All his major concepts—hierarchy of needs, peak experiences, intrinsic versus extrinsic learning, etc.—fit the description of our work. (Robbins, 1998, p. 71). The concept of self-actualization as described by Maslow was translated into the development of therapeutic goals as described by Nordoff and Robbins. Although this translation is not explicitly stated by the founders, it is evident in their clinical encounters. Maslow maintained that growth was the natural tendency and drive of a human being, who has a natural impetus to self-actualize. Similarly, Nordoff and Robbins operated under the assumption that a person's desire to respond musically can overcome a condition that stands in the way.

Another theoretical concept described by Nordoff and Robbins concerned what they called the "developmental threshold" which can be described as the point at which a client reaches the edge of his/her current developmental, musical capacity. Nordoff and Robbins believed that it is the role of the therapist to facilitate the client to move beyond their threshold. The therapist supports and accompanies the client as they move into the next developmental level. This concept parallels Maslow's hierarchy of needs, in which

Maslow states that when basic, fundamental requirements are met, an organism naturally seeks to proceed to the next level of personal development. It was believed that the music child would strive toward an aesthetic, relational, musical experience and that this progression would generalize into other areas of his/her life.

Nordoff and Robbins could be broadly considered situated within a humanistic framework as developed by Carl Rogers. The concepts of deep listening, meeting a person where they are, and integration of the self and the external world are commonalities between Rogerian theory and NRMT.

Summary of Salient Features

Rather than existing as a method or set model of music therapy, the NRMT approach represents a world view in which every person is seen as having the potential to realize heightened levels of development through active engagement in the creation of music. Improvised music is used creatively in every session with the therapist responding to even the slightest facial expression, physical movement, glance, or sound of any sort, with music that seeks contact with the child. In group music therapy there is a greater emphasis place on learning, “mastering” pre-composed music, and even performing.

Because musical materials evolve in each session, therapists dedicate a great deal of time following each session to listen to and study the music. All sessions are videotaped and documented so that significant responses may be noted, and musical ideas and new songs can be transcribed for future use. In reviewing each session, therapists may observe that a particular musical theme (e.g., an interval, motif, or rhythm pattern) or song evokes an instrumental or vocal response from the client. The therapist can then incorporate that music into the clinical repertoire to explore further in subsequent

sessions. Improvisations in NRMT are generally non-referential in that they are created entirely with musical considerations in mind, and without concern for features outside of the music to which to ascribe meaning. In NRMT music is used as therapy, functioning as the primary vehicle for the client's growth and development.

Nordoff and Robbins perceived through observation that active music-making had the potential of offering a child an alternate way of being in the world. Within a musical context, the child has the opportunity to communicate without the specific demands associated with verbal expressive language. Music can reframe isolating perseverative behaviors into relational coactivity. Additionally, music can motivate an individual to interact with others because the pleasure derived from the aesthetic experience increases with the heightened feelings of connectedness between the musical participants.

CHAPTER TWO:
RELATED LITERATURE: THE EVOLUTION OF NRMT

Purpose of Chapter

One way to trace how NRMT has been clinically varied and adapted by its proponents is through the examination of the writings and views of its most prolific proponents. The purpose of this chapter is to examine the development in the evolution of NRMT and its features. This is done through a review of contemporary writings pertaining to the work of the founders through the lens of contemporary NRMT practitioners.

The Growth of Nordoff-Robbins Music Therapy

The first history of NRMT was written by Clive Robbins himself in 2005. In *A Journey into Creative Music Therapy*, Robbins gives a personal account of how he and Paul Nordoff formulated the approach in the 60s and early 70s. In the book, Robbins reflects on their clinical work with children with various challenges. Robbins describes how from 1975 to 2005, the NRMT approach was disseminated throughout the world by trained NRMT practitioners, and through the development of training and research centers in various parts of the world. The book gives a biographical and sociopolitical narrative of NRMT. The clinical focus of the book describes how Nordoff and Robbins worked with clients, and how Robbins continued in the clinical tradition through his collaborations with Carol Robbins and other practitioners after Nordoff's death in 1977. Relatively little information was given as to how contemporary NRMT practitioners have clinically varied and adapted the approach to meet the needs of their own clientele[s]. NRMT has been practiced widely since its inception over 51 years ago, but we do not

know how the original concepts of NRMT have evolved clinically beyond the work of its founders. How have the work and ideas of Nordoff and Robbins been expanded and further developed?

Clinical Populations and Goals

One evolutionary development of NRMT pertains to the inclusion of additional and new populations. Whereas Nordoff and Robbins worked primarily with children afflicted with developmental challenges, other NR therapists have applied the model to adults with HIV/AIDS (Lee, 1996; Hartley, 1999; Neugebauer, 1999), cancer (Aldridge, 1999; Logis & Turry, 1999), schizophrenia (Pavlicevic, Duncan, 1994), dementia (Aldridge, 2000), and in palliative care (Aldridge, 1998), to name a few. One may wonder about the extent to which NRMT has had to have been adapted to meet the needs of such widely different clientele.

Individual versus Group Therapy

At the New York NR Center, Turry was influential in introducing more improvisation into group work. The original group work of Nordoff-Robbins consisted almost entirely of singing and playing pre-composed works; only occasionally did they do group improvisations with all clients participating. This shift in emphasis may be linked to changes in the client populations and their musical sensibilities, and to a more expanded view of the kinds of music appropriate to NRMT group work. In *Here We Are In Music*, Aigen (1997) traces the social and musical development of a group of verbal adolescents over the course of one year. During this time, the therapists began incorporating strategic improvisation into group work. Because the individuals were higher functioning than children typically seen by Nordoff and Robbins, this group of

verbal adolescents was able to grasp the concept of incorporating spontaneous feelings and ideas into the unfolding musical tapestry. This is an example of a trend toward the incorporation of improvisation into contemporary group work, a definite evolution of the approach as practiced by Nordoff and Robbins.

Roles of Therapist and Co-Therapist

The role and activities of the co-therapist is another area where change has gradually occurred in NRMT. Aigen (2005) introduced the notion of having the co-therapist support the primary therapist's piano work with the texture of a full rhythm section. The therapist, co-therapist, and, in this case, adolescent client, could be together in a musical "groove." This idea significantly expanded the traditional role of the co-therapist in NRMT to include playing a larger part in the music-making by enhancing and supporting the improvising of the primary therapist. Aigen entitled his book *Playin' In The Band* because he felt that the establishment of a band and the use of groove would be clinically valuable in working with adolescents. Aigen's expansion of the musical resources and instrumentation used in NRMT has provided a new perspective on the potential role of the co-therapist.

One evolution regarding co-therapy in contemporary practice, relates to the training and expertise of the co-therapist. Like the primary therapist, the co-therapist should be a highly trained and experienced music therapist, due to the nature of the NRMT training programs that exist around the world today. There currently exists no available training for non-musicians to become co-therapists, and so the role of co-therapist becomes a matter of logistics and dynamics of two equally qualified and

similarly trained professional music therapists. This is a major shift from Robbins' initial role as supporter, assistant, or facilitator.

In their 2005 article, Turry and Marcus describe teamwork as a defining characteristic of music therapy as practiced by Nordoff and Robbins. On the other hand, several NR therapists have been working extensively without the assistance of a co-therapist. This seems to be most common in work with adults (e.g., Lee 1996), in psychodynamic work (e.g., Robarts, 2003), and in those settings where it is not economically feasible (Verney, 2011). In present day practice, economic considerations often preclude the possibility of working with a co-therapist. Because we know that Nordoff never saw a client without his co-therapist, this represents another major evolution of NRMT.

Therapist–Client Relationship

Aigen (1998) presented eight case studies of clinical work done by Nordoff and Robbins in 1961 and 1962 from a psychodynamic perspective. These include three cases previously presented in *Creative Music Therapy* (i.e., Anna, Loren, and Martha), and five additional cases, including their work with Audrey, Terry, Walker, Indu, and Mike.

Loren was a verbally articulate 11 year-old boy whose issues were primarily of an emotional nature, leaving him socially isolated but with a seemingly inherent affinity for music. This case offers insight into aspects of the original concepts of the Nordoff-Robbins approach that relate to components of music psychotherapy, and may be ascribed to the characteristics of the clients with whom the designers worked. From this case it would appear that the founders devoted less attention to the dynamics of the therapeutic relationship than other contemporary practices in which self-reflection and

insight into the therapist's responses play a more significant part. "Instead, Nordoff and Robbins' practice supported the notion that music is the primary, if not the only, agent of change in this work, and it is the music which evokes and takes on the kinds of reactions which are typically more personalized within the context of the therapeutic relationship." However, "one cannot minimize the role of the relationship as an indice of clinical progress. Consider that the most important evaluation scale in Creative Music Therapy (Nordoff & Robbins, 1977) evaluates "Child – Therapists' Relationship in Musical Activity" (Aigen, 1998).

What seems to have changed in contemporary practice is the extent to which the therapist-client relationship is confrontational, particularly in the musical interactions. For example, a verbal adult with his own sense of direction may require less musical directiveness from the therapist. The question becomes: does the expansion of populations served affect the way a particular therapist will relate musically to his/her client? Many contemporary practitioners may not naturally embrace a directive stance, feeling that these elements were merely connected to Nordoff's personality, but not an essential component to the client-therapist relationship in NRMT. Over time, it becomes difficult to ascertain how much of Nordoff's relationship with his clients are based on the NRMT approach, or can be attributed to aspects of his personality.

Improvisational Strategies

Another area of expansion in NRMT has been in musical resources. In his work at the NR Center at NYU during my own tenure there, Turry followed his natural inclination to incorporate popular musical styles (e.g., jazz, Broadway show music) into his improvisations with clients. In his teaching, Turry encourages NR trainees to use a

wider range of musical resources, and to explore musical styles and structures that Nordoff and Robbins had not commonly used. Yet, Turry's incorporation of popular music styles is called into question in the work of Lee (2003) and Lee & Houde (2011) who emphasize a return to the styles of improvising advocated by Nordoff in *Healing Heritage* (Robbins & Robbins, 1998). In their work, one finds a renewed emphasis on the compositional aspects of clinical improvisation and an expanded view of musical resources that draws more strongly from world music and contemporary styles and idioms in Western art music (Lee & Houde, 2011).

The use of the piano to improvise with clients has been long-established in the NRMT tradition. In his work at the Nordoff-Robbins Center, however, Turry has played an active role in recruiting and encouraging the work of three guitarists: Dan Gormley, Rick Shoshensky, and John Carpentre. The work of these three therapists has contributed greatly to the use of guitar as a harmonic alternative to the piano.

Theoretical Foundations

When attempting to synthesize aspects of the Nordoff Robbins approach through examination of the founders' early writings and accounts of their clinical work, it becomes apparent that they approached each course of therapy and every client as unique. Extracting "foundational principles" from what the founders have said or written themselves becomes an exercise on the part of the researcher. This is due to reluctance on the part of the founders, to place definitive parameters that may limit future possibilities. The clinical case studies that describe their work emerge as providing the clearest window into the characteristics of improvised music interventions, within the unique, interactional relationship with each client. The clinical team and client explore together

how to move from “condition child” to “potential” towards “self-actualized” child.

Although foundational “principles” may be difficult to identify, it is possible to detect certain “recurring themes” that can help to clarify the world view through which Nordoff and Robbins approached their work.

In *Being In Music*, Aigen (1996) reports 14 “Theme Statements” on which he then expands in a Qualitative Monograph, published in The Nordoff Robbins Music Therapy Monograph Series. Categories of these themes are: Therapeutic Relationship, The Role of Values, Therapeutic Process, and the Demands, Implications, and Effects of Clinical Work, and the Nordoff Robbins Training. One of the most clearly established themes in Nordoff and Robbins’ work has to do with the concept of “work.”

The case of Audrey offers an example of significance Nordoff and Robbins placed on the concept of work. Audrey began music therapy when she was 7-years-old, while living at Devereaux, a large residential school for children with a variety of special needs in Pennsylvania. In this study we encounter examples that demonstrate how the team responded to resistive behavior exhibited by their client towards work by humorously framing a warm self-deprecating acknowledgement of their own needs to work within an authoritative role to build a more reciprocal relationship between them. Much of Audrey’s clinical process was work-directed. “This was manifested directly and overtly with the therapists insisting that Audrey work in therapy—her general development was seen in the way that she gradually acquired a positive attitude toward such goal-directed activity” (Aigen, 1998). This case also highlights the possibilities of relational mutuality that can develop from musical interaction. During the time they worked together, Audrey was able to reframe her view of the condition of existence, later

describing her experience as moving from living in a state of punishment for being bad, to one in which she had “a fighting chance of making it to the quality of life I have at this moment” (Aigen, 1998). This study was one of the eight offered by Aigen (1998) of clinical work done by Nordoff and Robbins in 1961 and 1962 from a psychodynamic perspective. These include three cases previously presented in *Creative Music Therapy* (i.e., Anna, Loren, and Martha), and five additional cases, including their work with Audrey, Terry, Walker, Indu, and Mike.

Nordoff and Robbins provided considerable insight into their exploration of the psychoanalytic concepts in relation to their work in the study of Walker. In the case study of Walker, we find references to the ideas of ego activity and function and of a “reconstruction of the inner ego organization,” with music acting as “the bridge connecting inner ego function and outer ego activity” (Aigen 1998).

Walker was a little more than 3-years-old when he began music therapy. He was born prematurely and his difficult birth was followed by a series of physical problems that resulted in three operations. He was described as being stubborn, aggressive, and tense, and probably would have, using present-day criteria, been classified as being developmentally disabled. During this brief course of 13 individual music therapy sessions, Nordoff and Robbins note subtle changes in musical responsiveness, indicative of the presence of increasingly developing psychological capacities. Resultant gains from Walker’s course of therapy are discussed in terms of the integration of his internal and external reality, and in the “pulling together” through relational musical co-activity of physical time, growth time, and “now” time.

Aigen's (1998) study of Terry also offers insight into how the NRMT approach incorporates aims and concepts inherent to psychotherapy. During this course of therapy, the clinical team worked towards finding resolution to Terry's internal, emotional conflicts, and the formation and discovery of a more fully developed and healthy "self." Terry presented as a 9-year-old boy, withdrawn and isolated, whose receptive language abilities far outweighed his expressive verbal capacities. He appeared fearful and quick to retreat from any situation he perceived as threatening. Terry made no efforts to assert himself. His course of therapy included 28 sessions, 2 individual sessions weekly, over a 5-month period in 1961. Terry also participated briefly in a music therapy group. Inherent to the NRMT approach is a belief that the therapist's ability to creatively draw from a variety of musical idioms, scales, modes, and styles is essential to effective improvisational clinical practice. It is worth noting that almost all of the music in the first 10 to 14 of Terry's sessions was in a Middle Eastern idiom. Nordoff's music, in this case, was quite dissonant, staccato, piercing, and provoking. Walker's and Terry's cases provide considerable insight into the development of the psychoanalytically informed aspects of Nordoff and Robbins' theory.

Streeter (1999) made a case for the incorporation of psychoanalytic concepts as well as a heightened awareness of psychological perspectives, including developmental theory, into what was becoming known as a "music-centered" approach to music therapy. Streeter objected to what she called an "absolutist" position, where the development of theory and practice would derive exclusively from music or music therapy, without regard to other related fields. Streeter raised ethical concerns over not taking a more inclusive approach. Streeter's article received quick responses from Aigen (1999),

Ansdell (1999), Brown (1999), and Pavlicevic (1999). Responses took positions that ranged from rebuttal to efforts to diffuse what, at the time, appeared to be a potential rift between differing points of view.

Turry (1998) tried to bridge the gap between the NRMT concepts “It’s all in the music” and “It’s all in the relationship.” He points out that one can work with an awareness of a psychological perspective while still being a music-centered therapist—that one can be psychologically minded and still thinking about the music. Evidence of this perspective is given in Turry’s article on transference and countertransference in NRMT (1998), where he documents how these psychodynamic constructs can be heard and felt in improvisations with the client. In this article, Turry offers evidence that NRMT can be successfully incorporated into theoretical orientations of psychotherapy other than humanism, which was most advocated by Nordoff and Robbins. In his book, *Music at the Edge: The Music Therapy Experiences of a Musician with AIDS*, (Lee, 1996) Lee explores the transference and countertransference that unfolds between a therapist and his client in palliative care. Other NRMT therapists who have considered their work within the context of a psychodynamic orientation include Etkin (1999), Pavlicevic (1997), and Robarts (2003).

Summary of Expansions

Based on the above review, it seems that those aspects of NRMT that have been most susceptible to variation and change are: musical strategies used with different client populations, the nature of the therapist-client relationship in NRMT, the significance and role of a co-therapist, differences between individual and group work, and musical styles and idioms used in clinical improvisation.

Missing in the entire literature on NRMT is a comprehensive overview of how these aspects of NRMT have changed. Given that current publications by proponents of NRMT focus only on how each proponent has adapted the method in his/her own work, little is known on how the approach itself may be evolving in different directions. To what extent are the musical strategies used in NRMT expanding because of its application to new populations? How is the therapist-client relationship evolving, and where does the co-therapist fit into the work? How has group work changed since its inception? And, what musical styles and idioms are currently used in NRMT? Based on the personal adaptations and contributions of NRMT practitioners, how has the model changed?

The purpose of the study is to better understand how contemporary practitioners are applying the NRMT approach with their own clientele, and to determine the extent to which their practices are consistent with the original approach as conceived and practiced by Nordoff and Robbins. In the next chapter, the actual clinical work of NRMT practitioners will be examined for further insights into these questions.

Problem Statement

The literature presents a scattered picture of the clinical evolution and development of NRMT since its inception in 1959. Robbins' (2005) personal account of the history of NRMT, describes its establishment and acceptance as a clinical practice, and its dissemination around the world. Robbins, however, reveals little about how the core clinical traditions have been maintained or changed by contemporary practitioners. Literature produced by proponents of the NRMT approach describe the ways in which each individual has adapted the approach to fit their own work with populations other

than those served originally by Nordoff and Robbins. These adaptations have undoubtedly contributed to the rich diversity of contemporary NRMT practice. Case studies in the literature also point to the ways in which NRMT practitioners continue to expand the original approach. What is lacking, however, is a comprehensive overview of how the NRMT approach has been expanded and adapted, and how the views and practices of NRMT therapists have enriched the original conceptions of its founders.

The purpose of this study was to determine how contemporary practitioners of NRMT have expanded and adapted the original approach as conceived and practiced by its founders, Nordoff and Robbins. Five main questions were posed:

What new musical strategies have been developed, if any?

How have conceptions about the therapist-client relationship evolved?

What is the current significance and role of the co-therapist?

How does individual and group NRMT differ today, in comparison to how they were originally conceived?

What personal adaptations and contributions have prominent practitioners made to NRMT?

CHAPTER THREE:

METHOD

Participants

Criteria for participation in the study were: 1) NRMT certified music therapists who have: 2) practiced the approach for at least 10 years; 3) published work in a music therapy journal or book that demonstrates their expertise in NRMT; and 4) given consent to participate.

Based on a review of the NRMT literature and rosters of the NRMT centers, seventeen potential candidates were identified. These seventeen candidates were asked to participate in the study by letter, stating the purpose and research questions involved as well as the context of the study (PhD Dissertation). Once the candidate agreed to participate, the researcher set up a face to face or telephone appointment for the interview.

Final participants of the study were: Kenneth Aigen, David Aldridge, Gudrun Aldridge, Gary Ansdell, John Carpente, Joe Fidelibus, Dan Gormley, Colin Lee, David Marcus, Nancy McMasters, Lutz Neugebauer, Mercedes Pavlicevic, Michele Ritholz, Rick Soshensky, Suzanne Sorel, Alan Turry, and Rachel Verney. The study was reviewed by Temple University's Committee for the Protection of Human Subjects, and approved as an "oral history." Thus, I adhered to all ethical guidelines and protocols for writing a "historical narrative" as established by the Texas Historical Commission in 1992.

Design

The interviews were conducted following the guidelines established in the Texas Historical Commission in its *Fundamentals of Oral History Texas Preservation*

Guidelines which defines oral history as “the collection and recording of personal memoirs as historical documentation. It documents forms of discourse normally not documented and it emphasizes the significance of human experience.” Oral history is normally not the best method for obtaining factual data, such as specific dates, places, or times, because people rarely remember such detail accurately. More traditional historical research methods – courthouse records, club minutes, newspaper accounts – are best for specifics. Oral history is the best method to use, however, to get an idea of not only what happened, but what past times meant to people and how it felt to be a part of those times. The same questions were presented to each interviewee. Interviews were conducted in-person when possible or were conducted on the telephone with the conversation recorded using Google Voice when geographic considerations made face to face interviews impractical.

Self-Reflection

As a practitioner and devotee of the NRMT approach, I am avidly interested in the evolution and development of this particular theoretical model. In the forty years since its inception an entire second and third generation of practitioners have carried on the approach, holding to its theoretical underpinnings with sufficient vigor to see the model spread to many countries throughout the world, including the United States, England, Australia, Europe, South Africa and the Far East. There are Nordoff-Robbins training programs in New York, London, Germany and Australia.

I had the opportunity to work closely with Drs. Robbins and Aigen on the production and dissemination of the Nordoff-Robbins Archive Series, a project which preserved and made available for study, audio recordings of the founders’ original

clinical work. Over the course of hundreds of hours devoted to producing the Archives, I have acquired an intimate familiarity with Nordoff's music. This has naturally led to questions related to how the clinical work of the succeeding generations of practitioners has evolved. It is my hope that knowledge gleaned through this study will contribute to the continued development of a clearly articulated theory regarding what defines the approach so it may be carried on by succeeding generations.

Situatedness

I studied the NRMT approach at the Nordoff Robbins Center at NYU in New York under the primary guidance of Clive Robbins, Alan Turry, and Michele Ritholz. I never had the opportunity to meet Paul Nordoff or Carol Robbins, and thus I am probably situated at the end of the third generation, if not the beginning of the fourth, of NRMT practitioners. Based on the inclusion criteria for participants in this study, I will be interviewing NRMT practitioners that belong primarily to the third generation of NRMT practitioners.

Data Collection Procedures

I compiled a list of potential participants based on the criteria listed above, and then reviewed the list with two of the participants, Drs. Aigen and Turry, to see if there might be more people that fit the criteria. After the list was completed, I sent each potential participant an invitation via email. See Appendix A.

Participants were not limited by restrictions related to how much time they could or should spend answering the questions. Actual times spent completing the interviews ranged from between 45 minutes and 90 minutes.

When logistically possible the researcher traveled to a convenient location for the participants to record the interview using an H2 Digital Recorder manufactured by the Zoom Corporation. When participants' location precluded face-to-face interviews a service called Google Voice was utilized, which allows telephone conversations to be recorded to a server for later access. Participants were asked to call a number that would send a ring signal to the researcher's telephone and the ensuing call was recorded.

Interviews were copied as MP3 files to the researcher's Hewlett Packard laptop computer and the conversations were transcribed using Microsoft Word and a digital audio file management application manufactured by Winamp.

Transcripts were emailed to the individual whose voice appeared as part of the particular conversation and, once approved, were incorporated into the study.

The researcher compiled the participants' responses by question/topic and assembled synthesized collective responses to each question according to topic.

Outline of Interview

The basic questions posed to the interviewees are listed below by topic. The questions were posed in different orders, depending on the flow of the conversation with each interviewee.

- 1) Musical Strategies: With what client populations do you work, and what musical strategies do you typically use with each of these populations?
- 2) Interpersonal Relationships: What kinds of interpersonal relationships do you try to form musically with each of these populations?
- 3) Working with a Co-therapist: How often do you work with a co-therapist? If you do work with one, what is the person's role? How does your role as the

primary therapist differ when you do or do not have a co-therapist working with you? In your opinion, how essential is the team approach in contemporary NRMT practice?

4) Differences between Individual and Group Work: How do musical interventions vary between group and individual work? How much music is spontaneously created in contemporary group work?

5) Personal Adaptations and Contributions to NRMT. To what extent have you adapted NRMT as originally conceived in order to meet the needs of different client populations? Can you talk about these modifications in detail, and in reference to specific populations? How do you think your own clinical work contributes to contemporary NRMT practice? Do you believe you have advanced the model, or have you tried to preserve it as originated?

6) Musical Styles and Idioms. To what extent do you incorporate various musical styles and idioms into your working musical repertoire?

7) Personal Views on the Evolution of NRMT. In your opinion, to what extent and how has the NRMT model evolved since its inception?

Data Analysis

The following steps were taken to analyze the data:

- 1) The entire transcript of each interview was read to get a sense of the whole.
- 2) The data from each interview were divided into sections based on each question.
- 3) The responses of the participant to each question were then segmented and coded segmentally.

- 4) The segmented and coded data of each participant were then re-grouped together by question. In this step, the data originally organized by participant was re-organized by interview question across participants.
- 5) The cross-participant data organized by question were reviewed to get an overview of the various responses to that question, and to identify possible themes in the data.
- 6) Similar and dissimilar topics were identified across participants for each question. Statements of the participants were then re-grouped according to topic.
- 7) The re-grouped data on each question were synthesized by topic, and a summary was written of all participant responses to each question.

CHAPTER FOUR: RESULTS AND DISCUSSION

The purpose of this chapter is to present and discuss the results of analysis and synthesis of the interview data. The chapter is organized into six main sections that correspond to six interview questions. They are: On Music, Interpersonal Relationships, On Co-Therapy, Group Work, Personal Contributions, and Evolution of the Approach.

On Music

During the interview process, NRMT practitioners were asked to describe any musical strategies they incorporate in their clinical practice. Although participants' responses varied, it seems that for current NRMT practitioners, an improvisatory stance is the primary strategy involved in the approach. The interviewees tended to discuss principles of improvisation, rather than about specific NRMT methodology, strategies or interventions. Below is a discussion of these improvisational principles they employ while working as Nordoff-Robbins music therapists.

Flexibility

Interviewees all emphasize the importance of maintaining a stance of what comes across as a fearless degree of flexibility and responsiveness as the music unfolds in the moment. This becomes possible by the therapist having acquired the musical resources necessary to respond freely to the client(s). Even when using pre-composed music, NRMT practitioners take an improvisational stance by being open to changing the music in response to what is needed in the moment. Soshensky explains: "I'm trying to stay in the flow of the energy and dynamics of the moment. Even if you're using a song that

you've played before, you're still improvising in the sense that you're relying on the moment to make a decision.”

Simplicity

Alongside the emphasis on technical and theoretical proficiency there is also frequent reference to Nordoff's ability to devise potent musical interventions within a simple musical context. For the most part, contemporary practitioners agree that NRMT clinicians strive to keep the music simple for a variety of reasons. If the therapist gets too immersed in their own complex musical process, he/she cannot remain fully available to respond to the needs of the client with immediacy and flexibility. McMasters tells her students that they “should be able to look at the client and play, not have to look down at the piano, and keep things simple enough so that you can remember what you played and go back to it.”

Simplicity in an improvisation often reveals the clarity of the therapist's clinical intent. Practitioners agree that Nordoff's clinical intentions were apparent in his music. Neugebauer avers that, “Nordoff stuck to a fairly conservative understanding of music—it's tonal, interactive, and about musical organization. In this approach one can always hear the potential of what might be possible. In a way, it is a perspective that only a composer could take.”

Lee also comments on the value of compositional thinking. Lee says, “Let's look at a Beethoven sonata, change the time signature and how you play it, and it becomes a drum song.” The therapist's ability to distill or reduce complicated musical forms into their basic components, allows melodies to be viewed as intervallic, sequential relationships, harmonies as sequences of chords, and rhythms as malleable patterns of

slow and fast notes. Lee believes that this process “is not rocket science. It’s really quite simple, but it’s a different way of thinking.”

Another reason to keep the music simple is that the client needs to be offered space and opportunity to actively engage in a co-active music making process. Therapists can easily overwhelm clients with overly complicated music, and this can discourage the client(s) from offering their own musical ideas.

Interviewees agree that there is no formula or method to achieve this musical simplicity and clinical clarity. Individual therapists need to find their own way, and this can only be done by continually exploring and developing one’s own musical resources. Simplicity and clarity have to be musically internalized.

Simple music is never meant to be boring music. McMasters stresses the importance of learning how to improvise with simplicity while the music remains “meaningful, expressive, and eloquent.” She discusses Nordoff’s clinical music, pointing out that even though he was a formidable concert pianist and composer, his musical choices were simple and easily conceived in small units. Although he was very specific about the music he chose, it was not his primary focus —“the child was the primary focus.”

When asked about their musical choices in a therapeutic setting, NRMT practitioners respond that the compositional elements with which the therapist responds are not prescriptive. In other words, there is no one musical answer for any given clinical situation. What is important, they agree, is that the music that is used is meaningful to the therapist and to the client, in that the therapist feels thoroughly comfortable playing, and the client in responding.

Working with Your Own Music

Neugebauer believes that “the approach is as individual to the therapist who practices it as it is for the client.” All interviewees agree that a guiding principle of the approach is the idea of using one’s own musicality in the service of a therapeutic purpose. Rather than imitating the relationship that Nordoff may have had with his client, the relationship between each Nordoff-Robbins therapist and their client becomes its own specific experience. The musical approach is the individualization of a general principle; that principle, according to Neugebauer, “is interacting in music and seeing personal development in the music.” Development may be measured by how relationally the client interacts with the therapist’s music.

Developing Musical Resources

Despite the agreement among NRMT practitioners that they each draw from a pool of their own internalized musical resources, there is also agreement that there is an imperative for therapists to continually develop different and new musical resources that can expand therapeutic opportunities.

To develop musical resources, NRMT therapists must constantly refine their musical competencies, maintain their openness to new musical forms and styles, practice what they need to learn, and incorporate new internalized material into their clinical repertoire. Turry feels that a significant part of the NRMT training is to encourage people to develop their abilities and to “own” the music they are playing. He believes that NRMT practitioners should see themselves, not as translators or interpreters of the music of others, but as music-makers communicating a personal statement. Like Turry, Lee emphasizes the importance of the musicianship of the therapist. “You need to listen, you

need to practice, and you need to do your homework.” For Lee, one cannot truly create engaging music without constantly refining one’s skills as a musician. At Laurier University outside of Toronto where he teaches, Lee conducts courses where students do not have to write papers, but have to practice an hour every day. He expresses concern over what he perceives to be an emphasis on writing and research in music therapy while therapists overlook the importance of musicianship. Lee believes that training programs should renew an emphasis on the development of musicianship and the acquisition of musical skills.

Listening

Learning to listen is essential to the training of a competent and effective musician; learning to be aware of verbal and nonverbal modes of expression is the most fundamental and unique competency of the discipline of music therapy. Contemporary NRMT practitioners maintain that learning to listen acutely is one of the ultimate defining principles at the core of the approach.

Pavlicevic states that “a fundamental of the approach is acute and detailed listening” to everything that the client and therapist experiences in the moment. “If we go back to [Nordoff and Robbins] work: What did Anna bring? What did Edward bring? They were able to bring particular kinds of vocal sounds and screaming and crying that were then imaginatively transferred into music.” Pavlicevic discusses this kind of listening in her own work. She advocates a heightened sensitization to everything present in the environment from the moment she enters the room.

Like Pavlicevic, Neugebauer believes that a defining characteristic of NRMT is a heightened quality of listening. “It is this quality of listening that makes the approach

valuable as a treatment method.” Neugebauer feels that words are not always the most effective way of communicating ideas and feelings. “One of the major strengths of music is that it offers a different way to be listened to as a client, a different way of expressing oneself, and a different way of interacting.”

Idioms Used

Participants were asked to discuss their use of musical idioms beyond what was utilized by Nordoff himself in the inception of the approach. Although Nordoff explored music from a variety of world cultures, he was primarily grounded in a Western European 18th – 19th century art music tradition, and often used idioms reflective of his musical background. Contemporary practitioners unanimously agree that Nordoff’s preferred and familiar musical world does not, and should not, define or limit the music used in contemporary NRMT practice. On the contrary, the interviewees believe that it is an ongoing responsibility of NRMT therapists to incorporate new and evolving musical material and idioms into their clinical repertoire.

Some practitioners express concerns regarding a shallow use of new musical material without the therapist’s full understanding of the cultural context of the music. Aldridge fears that the use of shorthand versions of rich musical traditions may act as substitutes to true the therapist’s true immersion in and understanding of the cultural context. Aldridge is concerned that some contemporary NRMT practitioners may have thrown away “the musicality that Paul Nordoff brought,” settling instead for the “lazy trick” of learning simple idiomatic stereotypes.

Lee shares Aldridge’s concern that therapists and students often do not make the effort to delve deeply into the complexity of cultural music. Lee believes: “We just

bombard our way through this music without any thought of its culture or where it came from, of the textures, of the sound.” Lee ultimately stresses the importance of cultural understanding in music therapy and feels that there is much untapped potential in the music of other cultures. He believes that therapists and trainees should not simply memorize shorthand cultural idioms, but truly “look at how that music is used in that culture. Otherwise” says Lee, “you’re going to bastardize it.”

Pavlicevic discusses the use of diverse cultural music in her own work. She says that the incorporation of cultural music in her work is necessary, especially because the United Kingdom is “a complex cultural place.” She believes that cultural awareness is necessary when working with diverse populations. Pavlicevic goes on to say that it is not only about understanding the music, but about understanding what health, illness and well-being mean according to other world views. Pavlicevic agrees that the pool of musical resources in NRMT “should always remain open, especially where people are working with asylum seekers, refugees, and political detainees—people from hugely different musical cultures.”

Marcus finds that, as time goes on, he uses different idioms more frequently, often finding himself “flowing into an idiom.” Marcus talks about one particular boy who had a tendency to “be a little bit separate from the world.” Marcus recollects that the use of the whole tone scale kept him involved and affected him deeply, possibly due to “the novelty of it, the strangeness of it—it seemed to attract him.” Marcus believes that choosing the best music in combination with the clinical needs of the situation, will “give us the effects we need: more intensity, novelty, interest, and curiosity.” Often times, unfamiliar,

complex, and culturally rich musical idioms will affect the clients in new and different ways, offering them new areas to explore, and other ways of being in music.

Dissonance

Turry speaks about the use of dissonance in a therapy session; he believes that although dissonance in music might not be immediately comfortable to hear, it is important that therapists cultivate the ability to use both consonance and dissonance with an awareness of intervallic construction. Contemporary practitioners agree that dissonance enlivens and sustains the flow of music and is an essential and expressive musical component; an NRMT therapist is able to use dissonance clinically.

Pulse, Rubato, and Groove

Despite the dramatic sociocultural changes taking place in the U.S. and Europe in the 1960's, Nordoff and Robbins were still trying to maintain their ties to Anthroposophic social circles, which adhered to strict dogmatic views based on the teachings of Rudolph Steiner. Aigen notes that within that context, Nordoff and Robbins "could be accused of primitivism just for letting kids play drums. Maybe it would have been too much to expect that they would use rock and jazz, the 'Devil's Music.'" The incorporation of contemporary musical elements that emphasized rhythm and "beat" would not have been considered polite or acceptable. The introduction of new, popular musical styles would not even come from Carol and Clive [Robbins] because "coming from the generation they did, they were of a mind that 'groove' involved a kind of mindlessness." Aigen believes that when Robbins and Robbins heard contemporary jazz or swing music, they were unable to appreciate its complexities and subtle variations. "When they heard jazz drumming, a swinging rhythm, dotted eighths, what they heard was a very a steady

tempo, mindless in the sense that it was the same part repeated over and over with no rubato. For them clinical music in NRMT music had to have rubato because that's what made someone awaken, become self-aware, and not go on autopilot." Aigen believes that he "pioneered the establishment of groove." Aigen believes that his musical background as a rock bassist influenced his incorporation of the associated musical components into his clinical work. Aigen believes this introduction of rock into NRMT therapy is "not an alteration, but an expansion and completely consistent with the approach."

Turley recalls that it took time for Robbins to accept the idea of using music with a steady pulse because, in Robbins' opinion, powerful emotions were expressed through the use of rubato, taking the music out of time. Turley believes the elements of groove and pulse did not resonate with Robbins. "Clive [Robbins] would hear jazz, blues, rock, etc. would say, 'That's just all excitement.'" Despite Robbins' reactions, Turley maintains that ultimately "Clive was open to take musicians like me."

Interpersonal Relationships

Although current NRMT practitioners maintain that music itself is the agent of change, perspectives are shifting to incorporate an emphasis on the importance of the extra-musical aspects of the client-therapist relationship. This relationship is based on personal and often verbalized interaction and emerges during longer courses of therapy than the founders were able to conduct. Additionally, current NRMT therapists increasingly recognize that NRMT can extend beyond the walls of a typical clinical setting to include school, family, and community. This section deals with how the traditional and contemporary client-therapist relationship is viewed, and how NRMT therapists work with teachers, families, and communities as clients.

Client–Therapist

When asked whether or not the therapist’s directive stance is a defining principle of the NRMT approach, responses varied. Some participants attribute Nordoff’s forceful position to facets of his personality, while others relate Nordoff’s willfulness to Steiner’s theories on the significance of will. Aldridge feels that an essential component of the approach, as developed by the founders, has to do with being directive in leading the musical development of the clients. Aldridge points to the theoretical basis for Nordoff’s directive stance as a parallel to Steiner’s concept of the will. Aldridge believes that “as a therapist, you had to have a will to [produce] change [in the client].” Aldridge goes on to say that “the therapist has to take on the moral responsibility to bring about the change. That’s the contract.” Aldridge dismisses the idea that Nordoff’s directive stance was merely a result of his personality, acknowledging the musical directiveness of Carol Robbins, a very different personality. Despite any views to the contrary, Aldridge maintains that, within the therapeutic session, Carol Robbins “knew what she was doing and went in the direction she thought things needed to go.”

In describing NRMT training, particularly in Germany, Aldridge believes that some of the essence of the original approach has been lost due to a lack of emphasis on the therapist’s responsibility for the direction of the therapy. Aldridge saw NRMT being taught as a “nondirective thing in which you let the client lead the way. But why would you do that? Why would you let a psychiatric patient lead the way, when what she is actually saying to you is, ‘Help me get out of here, keep me out of this!’ That’s what I thought was absolutely essential to Nordoff’s approach. He knew what he was doing. I think a lot of music therapists are afraid to be directive. Nordoff was such a supreme

musician, and he got that contact with the child, and he said, 'I'm the therapist, this is the way we go.' When I'm working, my attitude is, 'I don't take any prisoners.' As soon as you come through the door, and you say to me, 'I've come for therapy,' then you've said that you want to change."

Like Aldridge, Aigen views NRMT as ultimately about "leading clients, pushing, provoking, challenging, and using music deliberately." That Nordoff's clinical stance might be attributed to the time period in which he lived, or to personal characteristics, Aigen disagrees. "Nordoff penetrated people's haze and fog, using music to move through defenses, and I don't see most current practitioners able to do that. I think we're in danger of losing that whole facet of the work; it takes faith, confidence, and personal courage. Part of the issue has been that everyone who has done the NRMT training has been a music therapist with existing ideas about establishing trust, safety, and security." Aigen goes on to say that it may seem, at first glance, that Nordoff's way of working may be seen by some as antithetical to a thoroughly humanistic approach.

While Turry views the NRMT approach as being client-centered in the sense that music is created built around what the client is doing, "it is not only about listening, supporting, and reflecting back as the client unfolds. You feel Nordoff trying to break through or stimulate something. There is an implied hierarchy that people think of as 'bad' – that therapist and client should operate on a level of equality. But I don't think Paul ever said 'We're equal partners. Yes, we're equal partners in one sense because your music and my music are coming together and we are mutual.' But he was always being strong, doing it his way."

Fidelibus recollects the strategies of Carol Robbins and reflects on being the co-therapist with her in individual sessions. He recalls the clarity of her clinical intent. “It was about what one was being asked to do through the music. There was no vagueness to it.” Fidelibus believes that her ability to give “implicit instructions” played a vital role in her ability to engage children musically, particularly children with limited verbal skills.

Marcus frames Nordoff’s music in terms of containing tremendous energy. Marcus imagines Nordoff translating his musical intention into words: “The first thing we have to do is destroy what is dysfunctional and keeping you from being able to relate to me, in the way that I want you to relate to me, as a model of relating to everybody else. The music is either going to be too loud or too fast for you to deal with, and whatever is left of you, whatever survives, we’ll work with that.” Marcus recalls that there have been intense reactions to Nordoff and Robbins’ work, some of them quite negative, even though the results of the work were tremendously effective.

Marcus feels that therapists sometimes operate without acknowledging that eventually a course of therapy must reach its conclusion. Marcus believes that Nordoff and Robbins “were not trying to create a comfortable, holding, mutual kind of relationship that could last forever.” Nordoff and Robbins worked primarily within intense, short-term courses of therapy. Marcus explains that, in the case of some therapists, if the client doesn’t disrupt the week to week routine, it can go on forever without a clear emphasis on actual change taking place. Some therapists, Marcus believes, might imagine that the height of music therapy is, “Can I take this person who has difficulty relating to anybody and help them relate to me? That would require a kind

of music that Nordoff was not interested in making. I think that he learned that sometimes things need to be created, then destroyed, and then rebuilt.”

Although other practitioners avoid the term “directive,” preferring to identify with a more “client-centered” philosophy, there is consensus that Nordoff’s clinical stance was rooted in his own musical intuition, resulting in music that provided an obvious path for the client to pursue.

Family–Therapist

Sorel has been a pioneer in NRMT work with families. She believes that incorporating parents into the child’s therapy is a more effective way of meeting the child’s needs than to work behind closed doors with the child alone. This is a recent and somewhat uncommon development in NRMT. Sorel explains, “I have a very different philosophy now about engaging the parents of the children I see in therapy. I involve them in the process. However, I know that I’m using different techniques when I have parents in the room, incorporating and involving them in a variety of ways. I have a more inclusive approach when dealing with parents and I think that’s a direct evolution of the work.” Sorel’s experience with families is indicative of an evolution resulting from changes in points of delivery of service. In many cases of out-patient care, like Sorel’s work at the Rebecca Center, parents bring their children weekly to the clinic, and want to be actively involved the therapeutic process. Therapists have had to adapt beyond the typical experience of the founders due to the logistics of their situation.

Gormley’s work in an in-patient pediatric unit of a general hospital also brings him into close proximity to family members, who are often parents or siblings of the patient. If the family members are willing, he incorporates them into the session, actively

if possible. Gormley also plays music for people in coma. “That’s completely different insofar as I’m not encouraging them to make music with me. I am trying to play the most beautiful music I can for them. Often there is a family member present, and so while ostensibly I’m playing for the person in a coma, truthfully I’m also playing for the family members who are standing there or sitting with their loved ones. There’s an identified patient but there are also other people there that I’m trying to serve. There are times where I offer the chance for family members to make music with me for the person in a coma, and sometimes they want to and sometimes they don’t. So I encourage them to do what they feel is best. They may feel better just having me play for their loved one.” Gormley’s experience, like Sorel’s, indicates a tendency of current practitioners to involve family members in the therapeutic experience if they are open to being a part of the process.

Therapist–Music Teacher

Fidelibus has worked extensively at what he sees as the intersection between NRMT and music teaching. He has worked as a private music teacher with children with special needs, and frequently collaborates with music teachers in schools.

In his private teaching, Fidelibus found himself trying to determine the differences between therapy and instruction. “Having never really taught piano [to typically developing children], I had nothing to compare to what I was doing.” After having worked exclusively as a music therapist, Fidelibus wondered how to incorporate the acquisition of musical skills into clinical work. Fidelibus brings the improvisational attitude of NRMT into music lessons and achieves what he sees as a hybrid. “I start by creating a musical relationship, to be in music, and to meet the student/client wherever

they are, and see where we can go musically in terms of complexity and expression. I might ask ‘Can you figure out which fingers are 1, 2, and 3? Can you keep your hand in one spot and play this tune? A lot of kids have strengths that may not be apparent in other settings. They may be able to remember a melody, or they may have great visual perception, or are able to understand the spatial layout of the keyboard.’ When the time is right, Fidelibus shifts to the book, and asks the child to try playing what is written on the page.

Fidelibus also works with music teachers in schools, going periodically into the classroom to co-lead music lessons. His question is: “How can we help the children get into the music?” According to Fidelibus, the teachers are used to approaching lessons with very specific instructions and demands, more or less adhering to predetermined lesson plans. With children with special needs, Fidelibus notes, this may not be the most effective method. Fidelibus begins by encouraging the children to explore instruments and enter into interactive music-making experiences.

Fidelibus senses that teachers soon realize that they are musicians as well as teachers, and partners in music. “In this setting you are re-contextualizing group music-making in a school setting with people coming from an educational background, by bringing Nordoff-Robbins sensibilities into that arena.” Fidelibus finds it interesting that time and time again, teachers are amazed by what the children can achieve as the result of an improvisational approach. “This is a very different experience for these teachers and they’re going to hopefully keep incorporating it.”

Community–Therapist

Ansdell currently works with adults with enduring mental health problems in a rehabilitation day setting, to reintegrate people into their community. Ansdell describes his current work: “The format is a kind of large open-access group in a café setting. I use a combination of improvisation and repertoire that ranges from contemporary pop to blues to some rock, with an occasional selection from classical repertoire. It's also a performance space sometimes. I'd sum it up by saying that the ruling principle behind my work is an improvisational attitude; although I might not always be doing free improvisation, it's an improvisational attitude towards both the overall format of the event and to the material that's used. It's very free to use with people.”

As practitioners of the approach expand their work into school- and community-based settings, as well as their work with families, views and perspectives are naturally shifting to accommodate perspectives of new colleagues with backgrounds in education, social work, and systems theory.

On Co-Therapy

One of the most obvious and recognizable features of NRMT practice has been the two-therapist team approach. Although the two-therapist approach was a salient feature of the original model as developed by Nordoff and Robbins, current practitioners agree that the presence of two therapists in a music therapy session is no longer a defining feature of contemporary NRMT practice. Practitioners agree that a key component of being able to work without a co-therapist, while still working within the parameters of the approach, is to find a way to keep the clients engaged in the music. Gormley says, “I use the music as the way to make the connection and to engage the

person.” Alan Turry agrees, saying, “If you can’t work in the music, then it’s not Nordoff-Robbins. In other words, if you don’t have a co-therapist but you still feel like you can be engaging in your interventions with what you’re playing, then you’re still doing NRMT regardless of the number of therapists in the room.” When called for by the specific situation, having two trained NRMT therapists working together can help, but it is not a requirement to accomplish the work.

Pros and Cons

While there is an acknowledgement of the team approach as having played a significant part in the development of the model, contemporary practitioners have had to grapple with various factors that frequently make working in a team impossible. Ansdell describes a two-therapist team approach, not as an essential component of the model, but rather, as a practical response to specific clinical circumstances. “It’s very situation-specific. If you’re working with individuals who really need some kind of physical or musical help, there is a very clear rationale for using a second person.” Musical help from a co-therapist includes, but is not limited to, physical and visual cuing, presentation of instruments, etc. in order to make musical expectations more explicit.

Aldridge explained that he worked as a co-therapist with Neugebauer because “he’s only got two hands and uses both of them on the piano.” Aldridge goes on to say that, “You need somebody who can actually contain the child, in all senses of the word. Sometimes it is actually holding the child and helping the child to move. I think [that containment] is something that we miss [without a co-therapist]. Although the approach has evolved toward involving only single practitioners, I think the original approach holds something very important.”

Carpente further elaborates on the disadvantages of working without a co-therapist: “If I’m on the piano and I have to get off to make a physical, non-musical intervention, that’s going to influence the music being played.” If the therapist is giving full physical attention to the music, the child loses the physical support that might be needed. On the other hand, if the therapist interrupts or gives less attention to the music in order to physically intervene, the continuity and quality of the music can suffer.

Taking another perspective, Ritholz finds that some clients do not respond well to having two therapists, or literally a “third” person in the room. Co-therapy is “optimal unless it’s contraindicated by being overwhelming for the client, or if the client can’t relate with another person and two people would be just too much. We have to be able to make adjustments for all kinds of circumstances.” Although Ritholz believes that the spirit of the work can be carried on by a single therapist, she does admit that it is not always ideal.

Working with a co-therapist may also not be necessary when working with adults who do not have physical or mental limitations. In such cases, the two-person team approach can be undesirable, inappropriate, or contraindicated. For adult clients, the presence of someone else in the room may feel like an intrusion or loss of privacy.

From a psychodynamic perspective, Marcus believes that having a third person in the room “diffuses this individual give and take, power struggle, transference and countertransference, because all of a sudden all that is triangulated.” He goes on to say that “a lot of the possible conflicts that might arise in any kind of arbitrarily created individual relationship are dissolved because this isn’t that, this is a group.”

Clearly, the need for a co-therapist in NRMT varies with the particular needs of the client. However, there is another important reason why co-therapists are not always used, sometimes even when clinically indicated or necessary. Aldridge explains “we just can’t afford it anymore. It’s difficult enough finding jobs for music therapists, but finding jobs for two music therapists is even harder.” Gormley laments: “I wish that I had the luxury of a co-therapist, but I never do. I’m lucky that I’m being paid to do my job.” The financial realities of modern day health care have greatly affected the feasibility of two therapists working as a team, as was originally done by Nordoff and Robbins.

Roles of the Co-therapist

It is interesting to find that, even though co-therapists are no longer regarded by all practitioners as necessary or essential to NRMT practice, current practitioners offered very definite ideas about the role of a co-therapist when they are used. Perhaps the experience of working alone further clarifies and highlights the important contributions that co-therapists bring to the practice of NRMT. Clearly, the interview data showed that contemporary practitioners believe that co-therapists can be of inestimable value. They identified several important roles.

Musical Intermediary

Carpente looks to a co-therapist to facilitate the interaction between a client’s music and his own. Sorel agrees that the job of a co-therapist is to “facilitate the child’s involvement in the music-making experience and thus the child’s involvement with the primary music-maker.” When acting as a co-therapist, Sorel thinks of her relationship with the client as an “intermediary step” between getting the client closer to the primary therapist through what she’s doing.

Aigen believes that it is more crucial to have a co-therapist in a group setting than an individual setting where the “sculpting aspect” of the co-therapist’s work is essential to keep multiple people focused on the same task, and becomes necessary for “musical continuity” when trying to do compositions or improvisations with a group.

Physical Assistant

Aigen believes a co-therapist is essential when there are barriers to a client’s musical participation, whether those barriers are physical, cognitive, hyperactivity, or distractibility. Aigen remembers, “Clive always said that you don’t want to have to stop the music to go get a child. NRMT work is a musical experience where the uninterrupted continuity of the music is an important aspect of the intervention. I think the co-therapist is essential when the client’s ability to participate is in question.”

Sometimes it's physical containment that the co-therapist provides. Sorel believes “the co-therapist can help separate the room in a certain way, or focus the attention in a certain direction. It can be like an aura. It doesn't have to be a hand-over-hand prompting.”

Reflector and Witness

Turkey recalls Clive Robbins talking about being a reflector, and how important it is for the co-therapist to be “present.” Turkey recalls that Clive acknowledged the importance of where the co-therapist physically places him or herself in relation to the client, as well as how the co-therapist functions in the role of witness. Sorel also believes that a co-therapist functions as “a witness” to the music therapy process, as well as provides emotional support in the room. Turkey concludes, “These are the kinds of values

associated with having the co-therapist in the room. I see a place for that and I think that Clive has been an important component of the development of the work in that regard."

Model for Positive Interaction

Ritholz emphasizes the importance of modeling in co-therapy. "The modeling of an intact family, the modeling of an ensemble, of people cooperating, can be important outcomes of working with a co-therapist. I had a parent report that her son was able to play a game with his sister and she, and his mother wondered if it had something to do with music therapy."

Marcus talks about co-therapy as "modeling teamwork—people just getting along together and enjoying each other's company. If you're with two people who are hanging out together and having a great time, it's an easier place to be." He feels that there is a clinical benefit that comes with doing this work as a team. "Music is at its best and has the most potential with two therapists playing – there's more involved, it's more interesting, more magnetic."

Musical Participant

Turry describes how some therapists have become more musically active as co-therapists because as a way of engaging in the music that the therapist is making—not just for the client, but as a way of "getting in."

Aigen feels that a co-therapist may help establish a feeling of being part of a band, which can be clinically useful. He finds that working as a band brings with it a kind of camaraderie formed through music.

Being a Co-therapist

Ritholz points out that one of the most difficult things to teach about the NRMT approach is how to be a co-therapist. “When are you needed? How much are you needed? How do you help a person get started and then withdraw? This can be very confusing for people. It is a subtle thing to teach and there are different styles. In any one session you could be in any of those roles as a co-therapist—sitting with and listening to, emerging and receding.” Although the subject has been discussed over the years, there is presently no formal training offered for therapists to learn how to be an effective NRMT co-therapist. Turry discusses the issue: “People don’t come here to learn how to be co-therapists; they come to learn how to work as a musician/therapist. We toyed around with the idea of accepting people, who didn’t have the musical competencies, to come in and do the training as co-therapists because we thought that would still help them be better therapists, and I think it does. I think that being a co-therapist does help you when you go back to the piano or pick up the guitar again.”

Enlisting Support

In his pediatric work, Gormley sometimes enlists a child life specialist to help in a group session, “so in an informal sense they are a co-therapist, but it’s not like they’re a trained NRMT music therapist who is in the classic co-therapist role.” Sometimes Neugebauer asks parents to assist, which he finds helpful. “Sometimes the children won’t enter the room without their parents, so the parents take on the role of spectator and helper.”

As a therapist grounded in community therapy theory, Pavlicevic is familiar with bringing together volunteers and clients. “In the community work that I did on Friday

afternoons, there was music and movement, and it was bringing together volunteers in an affluent little town on the northeast coast of Scotland, mostly ladies who had their own issues in their own family lives, but their role there was doing charity work, helping children with special needs.” Working with a special needs teacher, they devised activities that incorporated music and movement, all of which she understood as being part of what music therapists do.

When working as a single therapist, Fidelibus frequently incorporates co-therapy techniques with an aide or a teaching assistant. However, he only encourages the participation of those educators who “could get immersed in the music.” When working with an educator within the therapeutic setting, Fidelibus believes that it is a matter of “knowing who they are, and knowing who we are, and what can we bring to this song. [If a teacher has] got a beautiful voice, I say, ‘Use your voice as much as possible. They’re paying attention when you sing!’ It is a matter of becoming aware of what their resources are as a musician. It’s been very gratifying.”

While contemporary practitioners acknowledge the importance of a two-therapist approach to the development of NRMT, they also agree that working with two trained NRMT therapists is, for the most part, neither possible nor necessary. In fact, there are instances where a co-therapist can be contraindicated. Verney sums it up by saying that it is perfectly possible to train people to function in the role of co-therapist who are not necessarily music therapists. “I think a lot more can be done on our own than perhaps was thought in the original training. The way of dealing with this subject has to be based in pragmatism: How many people have you got available? What money have you got? What do people need? I think the original concept was for a person to be totally focused

on the music, and another person to be there to help. With an individual, for example, to be there to assist physically, to enhance the musical message, the musical calling, the musical being which the therapist at the piano is providing, then I think that's fine, but it's expensive. A co-therapist is absolutely not essential to the approach. The approach is basically an understanding about the strategic use of music and the elements of music. It's not anything having to do with whether or not you have a co-therapist – that's an added extra.”

Marcus, on working as a co-therapist: “We’re playing music, and we’re together in this beautiful way—how can you resist? And the answer is, often they can’t! They want to do it too. The co-therapist puts out the message that, ‘I’m not paying any attention to you per se, I’m not asking you to do anything, I’m not telling you to do anything, but I’m having such a damn good time, you’re missing a big thing here.’”

Group Work

Of all components of NRMT, group work has probably evolved the most since the inception of the approach. The very purpose of group work in NRMT has varied considerably, not only according to population and setting, but also according to the extent to which the sessions involve improvisation versus performance of pre-composed music. This in turn has led to a questioning of whether these two musical undertakings are that different, especially when the therapist takes an “improvisational stance.”

Purpose

Aigen recalls that in their initial group work, Nordoff and Robbins simply brought together two or three individuals with whom they were working individually, and had each individual repeat what they had been doing in their own therapy. For example, when

they brought Martha and Terry together, Martha would sing the songs that evolved from her improvisational work with Nordoff and Robbins, and Terry would sing his songs. The purpose here seemed to be simply sharing one's own music with a peer. Aigen described this as "parallel play" rather than the kind of "interactive play" that defines group work today.

Then, according to Aigen, they took the next step and introduced the idea of compositions designed specifically for groups of children to play and sing together. An example of this was learning and mastering compositions such as Pif Paf Poltrie. Here the purpose moved beyond sharing with peers to learning how to actually interact with peers in music, albeit in a highly structured and predetermined way.

In both scenarios, group therapy was viewed as something that was undertaken after sufficient individual therapy had been completed. The children moved to group work only after they developed the musical and social capacities required to successfully participate in a group setting. Some contemporary practitioners still adhere to this idea. Ritholz explains: "some people are not ready to improvise, they don't know how to handle a mallet, they don't know how to respond to a phrase, to respond to this person. Those are tools to build a person's ability to express him or herself."

According to Aigen, the group composition approach "started to change in New York when Alan [Turry] started to create more spontaneously improvised songs." These songs came out of the clients' verbal, affective, or musical initiatives resulting in compositions such as "Brandon Is Crying on the Bus." This song reflects and acknowledges the difficulty a young man experienced on his way to school, and offered him an alternative means of expressing his feelings.

Ritholz views the emergence of improvisation in group work as a progressive process. “Yes, it was a progressive learning . . . Let’s move to the second generation where you find Carol and Clive [Robbins] working with a group together, “The Itch Song.” Something happened, a song was born out of an interaction in the group, the music brought everyone together and developed. There was more improvisation in that generation, and then in the next, my generation, even more.”

At the time, Aigen found great value in getting people to play together as much as possible, as this was the most effective way of actively creating a cohesive musical group. Aigen notes that another advantage of improvised songs was that they were less demanding than the group pieces that Nordoff and Robbins composed, which required more skill on the part of the client. Key to the success of such a group improvisation was the co-therapist, whose main task was to shape and structure the music. Aigen explains: “Choosing the right instruments and creating the right mood is tantamount to encouraging active and creative music improvisation within the group setting.” Here the purpose seems to have shifted from highly structured musical interaction to carefully guided improvisation, and perhaps from directed forms of interaction to a form of interaction that would best enhance the music-making experience and the quality of the music itself.

In the work he did with Kaoru Robbins, even though he was not at the piano, Aigen took an active role in selecting instruments, conducting, and shaping the sound, as well as taking a very active role in forming the musical output and creation of group improvisations.

Similarly, Turry considers the increasing use of instrumental group improvisation to be a significant development at the Nordoff-Robbins Center at NYU. For him, this made group work more consistent with individual work in NRMT.

Marcus believes that music can play different roles in groups, depending upon the individuals in the group involved. Music in a group setting may “organize activity and the whole environment so that people can know what to do and when to do it.” It also enables “people to interact together,” and offers members a place “where people can do or respond to the same thing.” Music offers a way for people “to persist and function in groups in ways that just sitting and talking wouldn’t allow.” Marcus believes that individual work “tends to be less of an imperative in that it wouldn’t be such a high priority for people to sit down, for example, or to behave in a relatively contained way.” Additionally, Marcus believes that “in individual work, people can behave in ways along a much broader spectrum of behavior.” Marcus explains that “in a group there is more social musical focus while what you might want to do individually is of secondary importance.”

Ritholz views the fostering of peer to peer social interaction as a fundamental contemporary NRMT principle in group work. In addition, Ritholz expresses the importance of the individual clients, “feeling part of a community.” She worked with a group in which two of the members had been in individual therapy for two years. Ritholz recognizes that the group becomes “like a family” and the members realize “it’s a place to be creative.” Ritholz goes on to say that the group members “have developed interpersonal musical relationships with one another that are just beautiful to see. They

care about each other. If one of them is not there you know there's going to be some singing about that.”

In summary, the purposes of group work in NRMT have varied widely, from sharing one's music with peers, to learning how to cooperate and interact in a pre-composed musical structure, to enhancing the music-making abilities of group members and the quality of the music, to facilitating spontaneous group interaction, to re-enacting family and social structures.

Pre-Composed versus Improvised Music

Though the purpose of group NRMT has evolved considerably, an issue that still remains is the extent to which pre-composed versus improvised music is indicated for group work. At present, there seems to be two basic approaches to group work: one is to sing or play pre-composed music almost entirely, and the other is to combine the use of pre-composed and improvised music.

Mostly Pre-composed Music

Contemporary practitioners have certainly not abandoned the use of pre-composed music, nor do they view it as outside of the NRMT philosophy. In group NRMT taking place in Germany, the musical emphasis has actually moved back towards working with pre-composed material, specifically, groups of people singing together in small choirs. They sing popular songs, seasonal songs, folk songs, hymns, and songs that people say they want to sing. David Aldridge explains, “We're actually doing what a lot of people did before as social workers, community workers, musicians, music therapists—we're singing with people. We have things like ‘A Day of Songs,’ across the whole region where we live. Throughout different clinics and institutions, people get

together and sing.” Aldridge describes these occasions as “basic community singing.”

Afterwards, Aldridge will invite those who enjoyed the experience to participate in music within a therapeutic setting giving them further opportunities to use their voice.

The Benefits of Pre-composed Music

Ansdell aims to work with people where they naturally gather, bringing them access to musicing in a free, dignified, and relational way. The people involved know him as a professional music therapist whose attitude is to work with them as a fellow musician. The program is called Smart Music and it meets in a cafe in a mental health center. In this setting Ansdell’s aim is not to do traditional therapy in terms of their problems or presenting symptoms, but “to facilitate a successful musical/social experience for these people who, because of their illness and their social situation, has meant that the opportunities for making music with other people are few. It gives people the opportunity to perform and to make music with others in duets, small ensembles, and all together as a big group. It gives them a chance to make music together in a way that is dignified, that respects their musicianship and their status as musicians. This particular community involves quite a few people who are trained musicians. If it were not for their illness, they would be semi-pros or professional musicians.”

Singing or playing pre-composed music in a group has many clinical advantages, the main one being that it imparts the musical and interpersonal skills that clients need to develop the ability to improvise. Contemporary practitioners believe that using pre-composed music in a group often precedes group improvisation.

One benefit of the pre-composed pieces, Marcus believes, is the development of the attention and focus necessary to participate. Pre-composed pieces demand that group

members are “able to learn, follow directions, and follow through with what they are being asked to do.” He goes on to say that this “is not necessarily true in improvisation.” Another benefit of working with pre-composed material, Marcus believes, is that the client is “getting something of a musical education in the sense that he/she is playing an instrument in the way it is authentically used in music, particularly if one is playing a melodic instrument.” Although the acquisition of musical skills in an educative sense is not, generally, the focus of therapy, Marcus believes that developing musical skills and awareness of musical form can have an effect when the individuals go back to improvising. “They may play a little differently or they may listen a little more closely. The improvisation can reach a whole other level.”

Using Pre-composed and Improvised Music

Many practitioners, like Marcus, believe in a “balance between improvised music and pre-composed music, as they each offer opportunities and possibilities that are important in a group context.” Depending on the stage of development of a particular group, improvisational music may offer inhibited group members the “understanding that they can just play, that everything they do is acceptable.” Ritholz believes that current group practice is still a “mixture of improvised songs and pre-composed songs,” as well as “improvised instrumentals.” Ritholz stresses the importance of always being flexible enough, even with a pre-composed piece, “to welcome something that is a surprise.”

Gormley relates that most of his group work in a psychiatric hospital is improvised, although he may use familiar songs in an improvisational manner. For instance, Gormley may adjust how often a verse or a chorus is sang, if he needs to put a 2 or 4 bar segue between a verse or chorus. Even when incorporating a structured song

there is flexibility within the structure. Because the groups of hospitalized in-patients are almost never the same from one session to the next, Gormley states that working on a piece like “Pif Paf” would not be possible. He goes on to say: “I do use quite a bit of structure in a group to help people to relate to one another and to help them to successfully express together.” With reference to this structure, Gormley says: “When I say structured improvisation what I mean is that most of the time I’m creating very clear structures with two or three different sections, like verse/chorus or verse/chorus/bridge. They may move in and out of different tonal centers but they’re always tonal and very rhythmically organized.”

Aigen views his contributions in this area as being significant to the development of the approach although he hesitates to take sole credit. “When people are improvising they are learning how to listen, how to moderate their playing, as well as developing skills that will help with pre-composed, tightly structured pieces. Those pieces can help develop skills that will be useful when improvising as well. This was another thing I think I helped pioneer within the approach - that we can use compositions as launching pads for improvisations. I tried to do that in the group setting where we would use the piece to create a mood and then say, ‘Let’s go off from there.’”

Verney maintains that a core quality embodied in Nordoff’s music is that all music is both structured and improvisational at the same time, and that actually, it is the flexibility with which the therapist works with the music that produces its qualities of salience. “It has nothing to do with pre-composed music vs. improvised music, but an improvisational attitude which the musician therapist has and which makes this work absolutely available and relevant to anybody. That’s the core of it.”

Marcus stresses the importance of using the pre-composed songs to provide some kind of foundation, but also being open to what may happen in the moment, “especially in transitions and in the individual responses that each participant gives you.” Marcus goes on to say that, for him, “it’s neither one nor the other, but one feeds the other. Pre-composed material can be a kind of springboard for improvisational work.”

The Improvisational Stance

Based on how some practitioners describe their use of pre-composed music, a new construct seems to be developing in contemporary group practice—the “improvisational stance” of the therapist. Essentially this means that the therapist is always either looking for an opportunity to introduce improvisational components to pre-composed music or looking for an opportunity to move directly into improvisation.

Going even further, Ansdell would “quibble with the hard and fast distinction between improvisation and pre-composed music” or what he calls “repertoire.” He does not believe it is a useful distinction. Rather, Ansdell thinks of things as being “on a continuum between the two.” Even when using a piece of repertoire, Ansdell discusses all moment-to-moment decisions he makes as improvisatory in nature. “You choose to play in a certain key, in a certain tempo, inflect it according to how the person can sing it, who wants to sing it. You adapt it in all kinds of ways. For me, that’s the improvisational attitude.” Ansdell elaborates on the idea of the improvisational attitude, saying: “You have a set of resources that are within you that are cultivated by you, but also that are cultivated by the other people you work with. It might be their resources, and then just like a conversation, you tailor it to that person, that situation, and those needs, and that always requires some form of flexibility, creativity.” Ansdell would go as far as to say

that “everything is improvisation really: musical composition, musical reception, and musical performance.” Ansdell believes it comes down to “taking something and doing it here and now in relation to the situation.”

Pavlicevic echoes the point made by Ansdell and Gormley, when she maintains that even when doing pre-composed music, “the truth is there is always an improvisatory element in whatever we do. It has to do with our improvisatory stance.” Pavlicevic clarifies her take on the “improvisatory stance,” saying “we may have a few musical schemes up our sleeve, what we’ve indexed from the last sessions work, but when somebody walks in this week and not doing anything that you were thinking they might do, you ditch everything and start from somewhere else.”

For the most part, current NRMT practice utilizes a mixture of improvised and pre-composed songs and instrumental pieces with an emphasis on being flexible enough, even with something that is pre-composed, to welcome something surprising. Current practice operates in a way that leaves space open for the unexpected, with the music therapist being able to decide what to take from arises in the moment. While the original approach utilized a good deal of pre-composed work in group sessions and spontaneously created compositions in individual sessions, current practitioners incorporate both pre-composed and improvised material in both settings. In the original concept, pre-composed music was recreated as notated on the original score. Current practitioners have adopted a stance of heightened compositional flexibility, where musical notation can become the basis of a freely moving variation. This pertains to what is ultimately an improvisational stance that emphasizes flexibility in response to anything arising in the

clinical setting. Essentially, the lines that differentiate pre-composed from improvised music have blurred.

Personal Contributions

When asked how they adapted or contributed to NRMT, all participants spoke in ways that indicated that they still fully subscribed to the basic principles of NRMT as originally conceived, and that they wanted to preserve it. For a variety of reasons, however, some also found it necessary to expand, adapt, or modify NRMT to meet the ongoing situational demands. It seems that both preserving and changing NRMT can be considered contributions, and even more interestingly, that preserving the spirit of NRMT may very well require change.

Preservation

Several participants specifically noted that they actively try to preserve certain aspects of NRMT that were being neglected. For example, Gormley strives to preserve what he considers to be the “spirit” of NRMT, even when working with different populations than its founders. Gormley believes that the spirit is one of truly trying to help people make the best possible music, inspire creativity which is empowering to them, and bring them into interpersonal relationships with both him as a therapist, and the people around them.

Lee views his contribution as having pulled the direction of musical focus back to where Nordoff left off with Healing Heritage, continuing on with a renewed emphasis on the compositional aspects of clinical improvisation. Lee feels that there are clues into how Nordoff worked in therapy to be found by studying how he thought as a composer. “If we go back to styles, every individual has their own style of playing. I play differently

than Alan Turry who in turn plays differently than other people. Even though we use all this music, every music therapist has their own defining style through which everything channels, and that's wonderful. That's how it should be. I can't be Alan Turry and Alan Turry can't be me. Paul Nordoff thought musically in a very specific way that I now see very clearly. It comes from how he thought as a composer and he carried this way of thinking into sessions." Lee's message to music therapists is to study music, composition, and the tools of music as the way to get into effective therapeutic work. "It feels important. I'm at that point where it's like I don't really know quite how important, but I just know it is."

Aigen views his research of Nordoff's work as an important reclamation of part of the model that might have died off, had his work not preserved it." In his research Aigen has tried to preserve the model as originated because he sees value in it. "I took pains to research Paul's [Nordoff] work and then Carol's [Robbins] because I felt that the work wasn't really understood." Verney also views her role in part as preservationist. She asserts: "I've been around so long I've seen the circle go round two or three times. I've gone from being seen as very radical to very traditional, and in a way that's irrelevant because the core is the same all the time which is wonderful." Aldridge adds that the original practice was "in the music, taking what another person brings to you, and using your intuition to make that musical relationship with the other person. That is the central thing about it, why we call it NRMT, why there's a Nordoff-Robbins Center, why we call it a NRMT approach. I am still working within what was set up initially, and all the colleagues here [in Germany] believe it too."

Ritholz and Aldridge both feel that, although it is difficult in today's economic climate, making the time to analyze or index therapy sessions is essential to the integrity of the approach. Ritholz comments: "I know in the world today it is not easy for people to find time to index, but we still do that here [at the NY Clinic], although we have had years when we've said, 'We don't have the time for this, we need to make time in the schedule for more clients, think of the finances.' But we can't give it up. When I don't index, I don't feel like I am grasping the process enough. I can still have a good session, I can still respond to my client but I am not building on something that happened spontaneously, that perhaps I don't remember. It is important to look at and listen to the session again, to realize, 'Oh, I missed that!' or 'I want to bring that back again, let me write that down and build on it.'"

Aigen identifies core values of the approach as the idea of working in and through the music, musical specificity, clinical rationale for what the therapist is doing musically, as well as leading, confronting, and challenging when necessary. "One thing that really surprised me when I heard a lot of Paul's [Nordoff] work, like Terry and Indu, was that it was so unlike what I had heard Carole [Robbins] do or anyone else at the [NY] clinic; nobody else played really harsh, dissonant, provocative music. I think that was an important aspect of the work in danger of getting lost if we do not really highlight and preserve Nordoff's more analytic work: that surgical, precise use of music to penetrate people's barriers." Aigen suggests that he has been able to re-encapsulate some of the core NRMT principles within a contemporary context, creating for himself a dual role of both traditionalist and innovator. "I think that part of the reason why people paid attention to what I said about Paul [Nordoff] was that I clearly wasn't someone who was

just stuck in the past—I also clearly had a contemporary sensibility. I think both perspectives give the other credibility.”

Marcus believes a basic NRMT principle that has somehow been lost is the idea that there is “musicality in everyone that can be elicited and brought forth; that that aspect of the person can assume a more important place in the person’s life and in the person’s development.” Marcus believes that this concept is essential. He elaborates: “Unfortunately, it was called the “music child,” because they were working with children, but to call that aspect a ‘child’ is almost limiting it, belittling it, because it’s much bigger and more powerful than that. It could be called a ‘music person’ or a ‘music alter-ego,’ or a ‘music shadow.’ You cannot just be making music together without looking for the aspect of the person as a coherent thing expressed through music, through a range of emotions and expressions that comes out in music. That’s part of what a Nordoff Robbins music therapist is doing.”

Expansion and Adaptation

On the other hand, based on the responses of participants, contemporary practice in NRMT has been expanded or adapted in five main areas: musical resources and strategies, applications, role of therapist or co-therapist, research, and theory. Each will be discussed below.

Musical Resources and Strategies

Turry reminds us of how rapidly musical expansion has occurred within the approach: “The only people who were doing the training in London and Germany were people at a 12th Grade Classical Level. Some of them could improvise while some couldn’t, but you were a ‘classical’ musician. It was only in New York, where Clive

[Robbins] was open enough to say, ‘We’re going to take people who are not classically trained.’”

Pavlicevic introduced the NRMT approach to multicultural spaces, as well as places with various musical cultures, particularly with her work in South Africa. “I believe I was probably one of the earliest to do that—we’re talking early 90s. It really made me think about how Nordoff-Robbins happens in a place where there’s already so much music as part of everyday life, as part of healing rituals, as part of understanding illness.”

Pavlicevic also discusses being “one of the first people to run music improvisation groups,” in the early 90s. Pavlicevic has also been a vocal advocate of NRMT therapists expanding their knowledge and truly “understanding what health, illness and wellbeing means according to other world views, not only our own.”

Musical resources have been expanded in idioms and styles, and in the use of alternative harmonic instruments in addition to the piano. Turry attributes New York Center influence as having played a key role in the addition of the guitar to the approach as a primary harmonic instrument. Turry expands on this: “Dan [Gormley] certainly pioneered that. I think having him here and by helping to establish Rick [Shoshensky] and John [Carpente], people can see that you can do the work with a guitar.” Gormley views the principles which define the NRMT approach to be the basis of his work. These principles, Gormley believes, have to do with “helping someone find, express, and develop their creative power as a force of positive change, to help that person build a therapeutic relationship with him [the therapist] as a part of that force for positive change.”

Soshensky recalls: “I started at NYU when it was just pianists who were doing the Nordoff-Robbins training. I never envisioned that I could be a part of that, even though I was interested in it. I loved hearing Clive talk about the work, loved reading the literature—but I didn’t really see myself as someone who could do the work because I was a folk-rock guitar player.” When Soshensky was later offered a place in the training course, it was what he considers to be “a profound moment.” He remembers: “It was like a moment of: ‘Wow, they’re thinking that way of me!’ I did the training pretty much classically, but playing the guitar.”

Although Carpenente considers his theoretical base to be rooted in the NRMT approach, he is developing a new theory which he calls Developmental Music Health. “I’m using the Nordoff-Robbins philosophy in practice, in the application of music, but how I conceptualize the client is a combination of different things—different from when it first started.”

As we know, contemporary practitioners have expanded musical strategies used in group work. Originally, NRMT group work consisted of performing composed pieces for voice and instruments, with only occasional options for improvised responses. In contemporary work, group work involves more improvisation, and a combination of improvisation and performance. In his work at the New York Center, Turry was influential in the introduction of more free improvisation taking place in group work. Pavlicevic and Fidelibus also explored group improvising in more educational settings. Ansdell works in an open-access group in a social community setting, developing the concept of what he calls the “improvisational attitude.”

New Clinical Applications

Contemporary practitioners currently work with a much wider gamut of client populations than did Nordoff and Robbins. Whereas Nordoff and Robbins worked primarily in school and residential settings with children or adults with developmental disabilities (e.g., autism, mental retardation, multiple disabilities), NRMT is now being practiced in many other settings with many other populations. Participants reported working with pre-school children (McMasters, Marcus, Turry), pediatric in-patient care (Gormley), mental health center (Pavlicevic, Gormley), HIV/AIDS (Lee, Neugebauer), Palliative Care (Lee), musicians (Lee), neurotic adults seeking counseling or having episodes of stress or depression in music psychotherapy (Sorel, Turry), adults with enduring mental health problems (Ansdell), adolescents, forensics, substance abuse disorders (Soshensky), institutionalized adult psychiatric patients (Marcus), geriatric, Alzheimer's, dementia patients, developmentally delayed adults and adults with autism, Down's Syndrome (Ritholz, Marcus) victims of stroke and family therapy (Aldridge, Aigen).

Interestingly some participants believe that the approach does not need to be adapted to accommodate different populations and settings, whereas others believe that it should be adapted. Gormley maintains that the approach is surprisingly the same regardless of population. He started working in pediatrics as his primary job at a hospital while up until that time he had been working in psychiatry. He thought the work would be very different but he was "struck more by the similarities than by the differences." He goes on: "Taking a client-centered approach and working to help people find their own creativity to express themselves and empower themselves through their creative

experience is the same.” Aigen agrees. He does not believe “the approach needs adaptation in any fundamental way as the populations change.”

Aldridge also agrees: “We use exactly the same principles—whatever the other person is doing, whomever you are sitting across from, whatever smallest movement they do, whatever gesture, whatever sounds they used, we use that and base the music that we make with them on that.” Aldridge expresses the importance of “making contact somehow in the music” and that because “everyone is seen as a ‘music person’ there aren’t inherent differences in the music based on age or condition.”

Verney sees herself as a traditionalist. “I trained 36 years ago, and music itself, the language of music, culturally, has moved on, but the basic attitude hasn’t changed. The approach is exactly the same, which is that you use whatever music there is in a very strategic way, and in understanding the experience that music affords. What I have done in my career is always to blaze a trail for the core teaching, which is about music and the strategic use of music for both individuals and groups. I have actually been a purist in a way, in sticking to that. On the other hand, I’m absolutely not a purist in terms of the next layer out, which is the form that it takes: for example, whether you need a co-therapist, whether you need a drum and cymbal and a piano. It’s not about, in my mind, instrumentation or format of session, it’s about the strategic use of music.”

On the other hand, there are different kinds of modifications of classical NRMT being practiced. Both Pavlicevic and Fidelibus have extended NRMT techniques to educational or instructional settings. Pavlicevic leads music improvisation groups in what is now known as Communicative Musicality Workshops where the therapist informs teachers of alternate ways of responding to children’s behavior. “Instead of telling the

child off for misbehaving, it's attuning to the child's behavior as a musician, and what this behavior can teach us about the child." Fidelibus uses musical instructions, both implicit and explicit, to allow children the opportunity to learn, in some ways still reminiscent of the educational component of Nordoff and Robbins' early work. Fidelibus recalls how in their group work, Nordoff and Robbins used charts containing symbols representing the melodic and rhythmic structure of the music, not traditional music notation of notes on a staff, but rather visual aids that used different colors for different instruments, lines of varying length that represented duration of notes so as to help the children learn the music they were working on week after week.

Lee credits his work with the Penderecki Quartet with having allowed him the opportunity to expand the role of music therapists. "The delicate and ever-shifting balance between the intricate musical components of improvisation and its therapeutic significance is never more clearly articulated than in this work" [with performers]. Lee's work with this quartet has been based on the understanding that a professional String Quartet must continue to function under the pressures resulting from concert schedules and the intimate interpersonal relationships the group members must develop. These pressures have the potential of resulting in physical and emotional problems. It was Lee's hypothesis that music could be used as a specific tool to deal with and aid these tensions. "Through this work I saw opportunities for a broadening that would perhaps challenge the boundaries of what commonly constitutes clinical practice." Lee hopes that one day every symphony orchestra, chamber group, and opera company will have its own resident music therapist to help its members face the day-to-day personal and musical challenges of ongoing professional work.

Sorel is now actively involving parents in therapy sessions for the children, as described earlier. This represents a significant change from the original model, as Nordoff and Robbins moved from one place to another, and did not really work closely with parents.

Role of Therapist and Co-Therapist

Sorel and Ritholz believe that they work using the core values of NRMT, while also bringing their own individuality into the work, as a therapist and as a person. They see NRMT as flexible enough to accommodate different personal styles of doing therapy. Ritholz values the importance of nonmusical interactions, as well as incorporating nonmusical tools. Ritholtz describes her own personal style as a primary therapist, as one that “holds true to the spirit of the work, which includes flexibility, extending forms, improvisation, and immediacy. The heart of the work is to use it like a rubber band, with give and take, with the possibility for enriching, for change, while holding on to a core: the idea of thematic music, compositional improvisation, form, melody—ideas that somebody can grasp. That’s very much a part of this work and it has always been.”

Marcus considers he has influenced the model by contributing to the development of a more active musical role as co-therapist. He and Aigen have been pioneers in terms of working a co-therapist who joins the primary therapist as another music-maker, each with different clinical and musical intents.

Research

Two proponents of NRMT who have made important contributions to the research literature are David Aldridge and Kenneth Aigen. Aldridge believes his major contribution to the NRMT approach was to encourage others to do research into Nordoff-

Robbins music therapy. Aldridge encourages research that is both evidence-based and what he calls “imaginative,” incorporating subjective aspects of the work into the research. Aldridge continues to be a prolific writer and researcher. Aldridge considers the ideas contained in the book *Melody in Music Therapy*, which he wrote with Gudrun Aldridge, to be his most valuable contribution. In the book, the writers explore the concept of melody within its historical context and investigate current theories of melody. They make recommendations for choosing an appropriate method of analyzing melodic improvisation, and utilize case studies to demonstrate these analyses in practice.

In addition to his previously discussed research on the case studies of Nordoff and Robbins, Aigen has published two ground-breaking qualitative studies. In the first study, *Here We Are In Music* (Aigen, 1997), he videotaped and analyzed one year of NRMT sessions with an adolescent group, conducted by two colleagues. In the second study, *Playin’ In The Band* (Aigen, 2005), he served as both co-therapist to Turry, and researcher. It was in this study that he explored the use of “groove” and the value of the co-therapist being an active music-maker as part of a “band.”

Theory

Adaptations and contributions to theory are somewhat difficult to define, as there are differences of opinion on what NRMT theory is, or even whether there is a theory of NRMT. Aldridge brings out a very interesting point: “We do not fully know how the founders actually looked at what they were doing because they never really came out and said it. What I mean by that is they were both Anthroposophists, they met at an Anthroposophical setting, they worked at an Anthroposophical setting, and all these things that they did around Europe were done to receive the blessing and the support of

these various Anthroposophical societies, which they wound up not getting. When it came to writing up or explaining what they were doing—if they were in a place that was a psychological setting a psychiatric setting—they explained it that way. I don't want to say 'camouflage' because that's too strong of a word, but we know how this goes: we've already been rejected once so we're going to put this in terms that not only can you understand, but that you are also very comfortable with. I don't know what they believed, or how much thought they gave it. That's abstract in a way and they were dealing with the concrete, individual nature of this course of therapy and this other course of therapy.”

Aldridge continues: “When you go back to what a theoretical basis he's had, Clive always told me that they had to come up with a theory, and the only thing they got was Maslow's hierarchy of needs. It was a book that he had on the bookshelf, so they used that. But if you go back to some of the Anthroposophical teachings that they used, the idea of will, and reinforcing the will of the other person, and using the will of the therapist, that made a lot of sense then.”

Another area of theoretical concern has been whether NRMT is a form of psychotherapy. Sorel points out: “Something that you'll probably hear not only in my interview but in others, is that even though the bulk of my work now and in the past 10 and even 20 years have been with kids mostly on the spectrum, the approach is different. It has evolved from the original approach because everybody has more of a music psychotherapy awareness. The work is being interpreted differently and because of that interventions differ. It's not just about populations changing—although, that of course has stretched—but it's also about philosophy and expansion, a different way of knowing about what's happening.”

Part of the controversy is over how one defines psychotherapy, how one defines music-centered therapy, and whether these two practices are mutually exclusive. McMasters has tried to bridge the gap between a sole emphasis on the music or the therapist-client relationship. She feels that she has helped people to realize that one can work with an awareness of a psychological perspective while still being a music-centered therapist. McMasters believes that one can be psychologically-minded and still be thinking about the music.

Another issue arises regarding whether NRMT should include verbal discussion in clinical work. Ritholz believes that this is sometimes necessary. Turry has tried to bridge the gap between “It’s all in the music” and “It’s all in the relationship.” Like McMasters, Turry feels that he has been successful in getting people to realize that one can work with an awareness of a psychological perspective while still being a music-centered therapist. He elaborates on this point: “I’ve tried to be who I am. I’ve been in psychotherapy and I think there’s a value to this. I think that there are reasons that therapy can be very powerful and profound in ways that have nothing to do with music and I think that can be useful for music-centered thinking.”

Evolution of the Approach

Pavlicevic believes that NRMT is just as relevant today as it was when it began. What makes it relevant—despite changing cultural, social, economic, and geographical factors—is the emphasis is on creating whatever music is needed in the moment as the session unfolds. It is not a set of procedures that remains the same. Pavlicevic believes the approach is “highly flexible, but no less rigorous for that. It is grounded in very solid principles of how music works, and how musicing needs to happen.”

Neugebauer agrees. “The original NRMT concept was flexible or wide enough to be adaptable to different client populations. I have never had to develop a new or adapted concept or theory to explain what I was doing. What I do has been of value to clients regardless of population. I have never had to reinvent myself as a therapist as I moved to new areas of practice.”

Neugebauer goes further and points out that one of the main accomplishments of Nordoff and Robbins is that they were able to describe and explain the therapeutic process in musical terms. Obviously, they knew that it could be described in behavioral or psychodynamic terms, but they insisted that as musicians, music therapists should understand that “music talks as music talks.”

McMasters sees NRMT as a way of working in music with a loving directiveness toward the client, as she saw Nordoff do. McMasters describes the Nordoff-Robbins music therapist’s ability to “lead a client to some place where they would not go on their own, with the confidence that they need to go there.” McMasters concludes by saying that when the therapist is “ethical and loving in how you lead and support your client, as parents and friends do. It is loving.”

Aigen imported the “groove” into the musical soundscape of NRMT. He explains how this happened: “Musically I am more attuned to groove than to melody— I couldn’t do some of the really nice stuff around improvising melodies, variation, playing around, embellishments—so what I did was more about shaping sound material and groove, flow, and intensity.” He believes this consistent with NRMT because he associates the approach with general principles rather than specific materials and procedures.

Gormley feels fortunate to have been the first guitarist invited to do advanced NRMT training. “Clive and Carol [Robbins] said, ‘This is an experiment, let’s see if it will work, we don’t know if it will work.’ I feel that I am staying true to that work in terms of what I believe is the essence of it. Specific idioms, what instruments are used, whether or not there is a co-therapist, I see these things as externals in terms of defining NRMT work. I see the essence of it as using creativity as a positive agent to help people cope with illness, with their situations, and to expand themselves mentally, cognitively, psychologically, physically.”

Although trained in the approach more than 35 years ago, Verney feels that even though music itself, and the culture in which it exists has moved on, the basic attitude of the NRMT approach has not changed.

Ritholz believes the approach has proven itself, in the right hands, to be adaptable to every population and situation. Ritholz believes that as the scope of populations expands, accommodations need to be made that take into account newly presenting situations; for example, incorporating a verbal component. She points out that there are current NRMT practitioners who believe it is helpful for some verbal clients to verbally process what happened during a session. This is perhaps reminiscent of a more Analytic Music Therapy approach, looking to bring unconscious material into consciousness. Ritholz comments on this: “Maybe we are going to places that the originators steered clear of or that didn’t come up, like talking without music.”

When asked about her contributions to the approach Sorel responds that it makes no sense to try to preserve the approach dogmatically. However she maintains that she has integrated the core values of the original approach into her work and into who she is,

and does not believe that the music aesthetic of it has evolved significantly. “It’s been filtered through a widened population base and expanded musical styles, but the spirit has remained true.”

Aldridge believes that he and his colleagues in Germany use the original NRMT approach (or at least employ the approach in their work as they were taught it) and adhere to the principles as they believe was originally done.

Regarding respondents’ views on the evolution of the approach, there is clear reticence among current NRMT practitioners to refer to NRMT as a “model,” more comfortable to refer to the practice as “an approach”—a philosophy or way of listening and relating to other people in the world, a way of being in music. NRMT is not a method in the sense that it contains a set of prescribed interventions or a specific repertoire of musical compositions. Practitioners are wary to articulate parameters that may oversimplify the work; this has reportedly been a collective thread connecting practitioners of the approach since its very inception. Even from its beginnings, there have been occasional disagreements regarding the incorporation of various concepts and ideas as being consistent with, or tangential to, the original approach; the waters of debate, however, appear relatively calm at the moment. For example, the contentiousness surrounding the incorporation of psychoanalytic theoretical concepts into the NRMT perspective which were roiling a few years ago seems to have subsided, at least for the moment. In general, current practitioners seem to be less rancorous when describing the differences between themselves than they have been in the recent past. Interestingly over the years, while finding points of opposition between each other, current practitioners

seem to consider themselves generally aligned with the approach as originally established.

CHAPTER FIVE:
META-PERSPECTIVE:
THOUGHTS, OBSERVATIONS, AND CONCLUSIONS

By all reports, practitioners of the NRMT approach, since its inception, have been flexible in reacting to newly emerging forces and events and adapting their practice to meet evolving situations. New developments in musical tastes and styles, cultural changes influencing societal attitudes, economic factors, and new populations in pursuit of change through music have influenced some aspects of the approach while leaving other aspects untouched. Nordoff and Robbins had an idea that there is part of the human organism that responds to music regardless of physical or psychological obstacles to typical functioning. This concept could not be supported by hard scientific evidence at the time. In recent times, however, technology has evolved to the point where specific, separate areas of the brain have been observed responding exclusively to music. The musical context elicits unique responses at the deepest neurological levels.

As I spoke with the participants in this research, it became clear to me that the NRMT approach is more of a way of being in music than a method, more of a philosophy, a point of view, or a way of being in the world of musical communication. It is difficult to trace the evolution of an “approach” or “philosophy,” especially one like NRMT, because the approach is broad enough and flexible enough to allow for variations that do not necessarily challenge its core notions. What I discovered is that although many of the more obvious features have changed in response to evolving situations, the basic approach has not. The belief in the potential for change through the dedicated commitment to the creation of the most effective clinical music one can make is what I

have gathered to be the essence of the approach. It is the distillation of the compositional elements of different musical styles and idioms into potent clinical interventions that both defines the approach and accounts for its effectiveness. The approach is based on engaging any person in co-active music making with an acute compositional awareness on the part of the therapist. It is maintaining a compositional perspective, redesigning musical elements, and in a spiritual sense, maintaining a melody with someone else's being.

Colin Lee argues convincingly that a crucial and perhaps overlooked component of music therapy training in general is the acquisition of musical skills. What sets NRMT apart in many ways is the rigorous musical training, the demand of excellence in musicianship, and an ongoing vocational effort in the acquisition of furthering musical skills.

Rather than viewing musical strategies as *components* of NRMT, strategic musical thinking *is* the approach. Although one might define all music therapy as strategic musical thinking, it is the aforementioned seriousness and dedication that truly distinguishes the NRMT approach from other music therapy practices. For example, regardless of circumstances regarding employment, every Nordoff-Robbins music therapist participating in the study emphasizes the importance of musical analysis as a necessary component of NRMT clinical practice. While most music therapists do some form of documentation, Nordoff-Robbins music therapists are trained to extensively analyze every nuance of a session moment-to-moment, with the use of an audio or video-recorder. This method of indexing is distinct from other forms of clinical documentation. Minute analysis, coupled with the resources available to a highly trained musician, allows

a high degree of significance and intent to be placed on each musical choice made during a clinical encounter. These musical choices include: the use of any and all available musical styles and idioms; the instruments selected or made available; where the instruments are placed in the room; the volume and articulation with which each note is played; harmonic extensions or other alterations to form, melodic structure, intervallic relationships, etc. Theoretically, the exactitude with which NRMT therapists make these decisions creates the most opportunity for therapeutic growth.

In terms of the music created during a session, NRMT is an approach in which the musician is expected to spontaneously compose music in response to what arises moment to moment. The practice and experience gained during NRMT training, allows the therapist to become comfortable enough to use improvisation and composition effectively in therapy.

NRMT therapists never expect to cease learning, and are constantly expanding their understanding of the music world. They are always curious to hear something new and engaging. By placing such an emphasis on the importance of learning the music of other cultures, an NRMT therapist comes to deepen their level of understanding of humanity. This not only opens up a pool of resources, but gives the NRMT therapist other ways of being in music. This is the planet we live on. This is a way of being: If you take music seriously, it becomes the most important thing: the way you talk, breathe, think—it's everything.

Working with a co-therapist is not a consideration for most music therapists. NRMT training offers music therapists a special opportunity to exponentially increase the effectiveness of the therapeutic process. Adding a co-therapist to the equation may not be

absolutely essential to define the approach, but the opportunity to work with a co-therapist in NRMT is unique and offers tremendous possibilities.

Within the NRMT approach, there are many different styles of developing interpersonal relationships in a therapeutic context, and the relationships that develop may have different qualities. One aspect of the client-therapist relationship involves the level of musical directiveness on the part of the therapist. Many practitioners avoid the term “directive,” preferring to identify with a more “client-centered” philosophy. Even so, there is consensus that Paul Nordoff’s clinical stance was rooted in his own musical intuition. This intuition provided an obvious path for the client. The question becomes: How much of Nordoff’s clinical stance is vital to the practice of the approach, and how much is merely a reflection of his personality? I personally believe that it is the responsibility of the therapist to actively lead the client toward growth and health as efficiently and expeditiously as possible. Nordoff-Robbins music therapy may be client-centered in that any client-initiated action, musical or otherwise, is met with the utmost respect and incorporated into the music. However, the therapist, having met and accepted the client musically and personally, is then obligated to move them forward; This process may not always be comfortable, may not be easy, and may not be the way the client would proceed if they were given the choice. A client in therapy has abdicated a degree of autonomy, to be in the hands of a capable, empathic, caring professional with their best interests at heart.

Ultimately, what sets the Nordoff-Robbins approach apart is the degree to which the therapist has truly learned to listen: to another person’s music, to another person’s being, and to themselves. This is more than musical ear training; this is learning to listen

at a spiritual level. If one believes, as I do and as Nordoff and Robbins did, that one can really know a person through their music, then NRMT offers the client a way to be fully heard by someone who truly knows how to listen.

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Appendix A

E-Invitation to Potential Participants

Dear X,

I write to ask if you would be willing to spend a little time on the telephone with me to answer some questions regarding your ideas about contemporary NR practice. I am doing this interview research as part of my dissertation at Temple University. I will be conducting the interviews following the ethical guidelines set by the Oral History Association. I will record and transcribe the interview, and then return the transcript to you, to allow you to edit, redact, augment, or otherwise further explicate whatever is deemed appropriate. I will be compiling and synthesizing the responses, changing first person responses of yours to third person. I will not be using a lot of direct quotes. I really would appreciate your participation. Perhaps you might let me know a convenient time when we might talk?

Thanks,

John Mahoney, MT-BC, LCAT