

In Search of the Self: The Use of Vocal Holding Techniques
with Adults Traumatized As Children
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How does one lose a self? It can be sacrificed at birth to fill up an empty parent. It can be shattered into fragments from unspeakable terrors like abuse, neglect and emotional and/or physical abandonment. It can become numb, deadened to life as the only way to exist in an unsafe environment. Or, essential parts of the self can be hidden away because when they first came forth they were not welcomed, seen, understood and valued, but were judged, shamed and rejected for being too different, too needy, too much. Sometimes, the authentic self retreats into an inner sanctum because it was envied and even hated for the bright light of potentiality it possessed.

Analysts and psychiatrists have various ways of describing this phenomenon. British object-relations theorists like Winnicott (1965) and Miller (1981) speak about the loss of the true self; the young, feeling part of the personality, and its replacement by a false compliant self. This psychic split is caused by a chronic lack of empathy and/or erratic, overstimulating or grossly neglectful behavior on the part of the primary caretaker.

Masterson (1988) describes how the healthy, individuating real self can become impaired early in childhood when threatened with abandonment by the mother. This leads to the creation of a protective false self that suppresses painful feelings and impedes autonomy.

In Jung's (1947) view, the psyche tends toward dissociability and is comprised of complexes or part-personalities. Critical injuries to one's developing sense of self could result in the ego's identification with one complex (for example the parental complex), to the exclusion of others. In his theory, one part of the psyche is

capable of actively attacking and persecuting another part, thus causing it to recede from consciousness.

Different manifestations of “self-loss” have been given different labels by the psychiatric community over the years. Narcissistic, Borderline, Schizoid and other personality disorders are the terms that have been used to describe the wide range of symptoms and defenses that occur when connection to one’s authentic and vital center of being is broken.

Many of my clients, however, describe their plight in more poetic and poignant terms. They speak of being hidden inside a cocoon, trapped behind a glass wall, enclosed inside a bubble or hovering around the edges of life, longing yet afraid to enter. Alice alternately perceives herself as a helpless child or evil incarnate. Sandy thinks she is broken. Mike feels there is nothing inside of him except a black hole, and Beth doesn’t know who she is; she just wishes she would stop having such horrible nightmares.

These clients are all in various stages of working through unresolved trauma. The traumatic experience as well as the meaning attributed to it, critically affected each person’s experience of self and his/her capacity to participate in an intimate relationship (Ulman and Brothers, 1988). Trauma is used here to refer to any experience that causes the infant or child unbearable psychic pain and/or anxiety. Since the rupture, breach, shock or shocks occur before a coherent ego and its defenses have been adequately formed, the intense affects are too overwhelming to be metabolized and processed normally, thus, the devastating effects on the traumatized person’s body, mind and spirit (Herman, 1992; Kalsched, 1996). Some of these effects can be observed in the way traumatized clients often alternate between a state of “overwhelm” and intense reexperiencing of the trauma, and a state of emotional constriction and numbing which can include avoidance of people,

places and events that might trigger traumatic associations and bring on intolerable anxiety or panic (Van der Kolk, 1987; Levine, 1997).

Traumatic experiences encompass a wide range of occurrences from the horrors of sexual and physical abuse to the more cumulative traumas of unmet dependency needs, inadequate nurturing and interruptions of the attachment bond. Common to all these experiences is the rupture to the integrity of the self and the feelings of confusion, helplessness and terror this rupture evokes (Terr, 1990; Kalsched, 1996).

The inner world of the traumatized client contains split off, dissociated parts of the self which are often externalized in the client-therapist relationship and can be worked with in the transference-countertransference situation (Davies and Frawley, 1994). In music therapy, the relationship field is enlarged to include transference and counter transference to and in the music. Parts of the self can also be projected onto the voice, the music and the musical instruments (Austin, 1993).

Clinicians who have studied trauma from different theoretical perspectives have discovered the prominence of one dyadic structure that results from a split in the ego or personality of the client. This dyad consists of a regressed part usually “feeling” in nature and a preciously advanced part usually associated with mental processes (Kalshed, 1996). This advanced part persecutes the regressed part in what seems like a misguided effort to protect it from the dangers of connection to the self and others. Getting close to others is perceived as dangerous because the primary caretakers of infancy and/or childhood were undependable, neglectful or abusive. Making connections among the self-parts is threatening because psychological survival once depended upon the ability to disconnect thoughts from feelings and to emotionally distance oneself from experience.

I turn to my clients once again for vivid descriptions of the inner persecutor: the

witch; the predator; the beast; the rapist; as well as the inner victim: the orphan; the hurt puppy; the broken doll; the homeless man. These images are personal and archetypal in nature and they emerge in dreams and in creative expression like vocal and instrumental improvisation (Austin, 1991, 1993, 1996, 1998, 1999).

Primitive defenses like denial and dissociation protect the self from annihilation but also affect the integrity of the personality. Severely dissociated clients experience the self as enfeebled, fragmented and/or lacking in continuity. Clients who were unable to form a secure attachment to the primary caretaker and/or lacked an emotionally available and consistent “good-enough” mother (Winnicott, 1971), have an accumulation of unmet dependency needs that pave the way for problems with identity formation and self-esteem regulation. Without a fully developed sense of self as a basis for ego functioning, these clients are compromised in their ability to function as mature adults. “Adult-children” like Peter, describe it this way, “I wake up every morning feeling anxious and all I want to do is hide under the covers...I know I look like a grown-up and I have an important job and everything, but I feel like a fraud and it’s only a matter of time before they find out I’m faking it.”

So how do we help these clients recover from unbearable life experiences so they can have access to more of themselves and feel more authentic and alive? I have found the combination of improvised singing and verbal processing to be one very effective way of working with the unresolved traumas of childhood.

Giving Trauma a Voice

Children who are raised in an atmosphere of fear, hostility, violence or neglect; children whose parents are alcoholic, emotionally disturbed, or absent (physically or emotionally), have been silenced. Sometimes this silence takes the form of withdrawing into a private world and choosing not to communicate because it is not

safe to do so. Sometimes the silence is selective; some things are allowed to be talked about, some feelings are allowed expression and others clearly are not. Sometimes the silence is loud; words and feelings come tumbling out but fall on deaf ears or are beaten down and stifled. Needs and feelings remain unmet and the voice becomes inaudible, tight and tense, breathy and undefined, or simply untrue; perhaps lovely to listen to but not connected to the core of the person. In essence, the traumatized person often survives by forfeiting her own voice.

The process of recovering one's true voice involves reinhabiting the body. As previously discussed, the dissociative defenses that initially protect the psyche from annihilation, sever the connection between the body, mind and spirit. Embodiment requires the courage to remember and experience the sensations and feelings that were overwhelming as a child, intolerable because no one was present to help the child contain, make sense and digest the intense affects.

Singing is restorative for a variety of reasons. On a physiological level, singing facilitates deep breathing. In order to sustain tones one has to take in more air, thus expanding the belly and diaphragm, and then has to fully release the breath in order to continue the process. This kind of deep breathing slows the heart rate and calms the nervous system, stilling the mind and the body. Relaxation is the result, a state that is beneficial to everyone but especially helpful to anyone in a state of panic or extreme anxiety who is hyperventilating, or breathing in short, shallow bursts.

There is a reciprocity between the physiological and the psychological effects of breathing. By restricting the intake and release of breath, we can control our feelings. This is obvious when I watch clients hold their breath after revealing an emotionally charged issue. When encouraged to exhale fully, they often come in contact with a feeling they have been suppressing. Likewise, the inability to take in nurturing or other kinds of experiences

and information is mirrored in restricted inhalation. The way we breathe influences how we feel and what we feel has a direct effect on how we breathe.

Singing is also a neuromuscular activity and muscular patterns are closely linked to psychological patterns and emotional response (Newham, 1998). When we sing, we are the instrument and the vibrations that we produce nurture the body and massage our insides (Keyes, 1973). Internally resonating vibrations break up and release blockages of energy allowing a natural flow of vitality and a state of equilibrium to return to the body. These benefits are particularly relevant to traumatized clients who have frozen, numbed off areas in the body that hold traumatic experience. According to Levine (1997), this residue of unresolved, undischarged energy gets trapped in the nervous system and creates the debilitating symptoms associated with trauma.

Singing can enable the traumatized client to reconnect with her essential nature by providing her with access to, and an outlet for, intense feelings. Singing offers a way for the disembodied spirit to incarnate because the way home can be pleasurable and the painful feelings can be put into an aesthetically pleasing form. Lynn explained it this way: “When I sang just now, I took something ugly that happened to me and made it beautiful.” The structure inherent in songs and present in vocal improvisation can shore up a weak inner structure in the psyche and help contain strong emotions thus making it safer to express them (Austin, 1986). The act of singing is empowering: sensing the life force flowing through the body; feeling one’s strength in the ability to produce strong and prolonged tones; experiencing one’s creativity in the process of making something beautiful; having the ability to move oneself and others; and hearing one’s own voice mirroring back the undeniable confirmation of existence. Owning one’s voice is owning one’s authority and ending a cycle of victimization.

Vocal Holding Techniques

Vocal holding techniques is the name ascribed to a method of vocal improvisation I developed and codified that involves the intentional use of two chords in combination with the therapist's voice in order to create a consistent and stable musical environment that facilitates improvised singing within the client therapist relationship. This method provides a reliable, safe structure for the client who is afraid or unused to improvising; it supports a connection to self and other and promotes a therapeutic regression in which unconscious feelings, sensations, memories and associations can be accessed, processed and integrated. These unconscious experiences are directly related to parts of the self that have been split off and suspended in time due to traumatic occurrences. When contacted and communicated with, these younger parts can be reunited with the ego and the vital energy they contain can be made available to the present day personality. Developmental arrests can be repaired and a more complete sense of self can be attained.

Unlike jazz or other forms of clinical improvisation where shifts in harmonic centers are to be expected, this improvisational structure is usually limited to two chords in order to establish a predictable, secure musical and psychological container that will enable the client to relinquish some of the mind's control, sink down into her body and allow her spontaneous self to emerge. The chord pattern is played repeatedly as a basis for the client's improvisation. The simplicity of the music and the hypnotic repetition of the two chords, combined with the rocking rhythmic motion and the singing of single syllables (sounds, not words initially) can produce a trance-like altered state and easy access to the world of the unconscious. The steady, consistent harmonic underpinning, the rhythmic grounding and the therapist's singing encourage and support the client's vocalization. Within this strong yet flexible musical container the client can explore new ways of being, experience the freedom of play and creative self-expression and allow feelings and images to

emerge. (Austin, 1996, 1998, 1999) The client's voice, feelings, and emerging aspects of the self are all held within this musical matrix.

This method is especially useful in working through developmental injuries and arrests due to traumatic ruptures in the mother-child relationship and/or empathic failures at crucial developmental junctures. Interpretation and illumination of psychic conflict is of minimal value in working with adults traumatized as children, until the link between self and other is rebuilt and the client's capacity for relationship is restored (Herman, 1992; Hegeman, 1995). Improvised singing seems ideally suited for this reparative work. The voice is a primary source of connection between a mother and her child. Even in utero, infants begin to recognize the voices of those who will care for them. Babies begin to vocalize at around five weeks of age and the attachment between the infant and its caretaker develops slowly over the baby's first year of life through physical closeness and an ongoing dialogue of cooing, babbling, gazing and smiling. The gaze between mother and infant contributes to the vocal rapport between the two (Bowlby, 1969; Winnicott, 1971). Vocal interaction in sounds, song and later speech are critical to the child's development (Newham, 1998). Tomatis (1991) has even suggested that the mother's voice is just as important to the child as the mother's milk in providing adequate relational bonding. The importance of the voice and vocal holding in building and repairing the connection between self and other has significant implications when working in depth with clients suffering from the consequences of pre-verbal wounds to the self.

Vocal holding techniques are not meant to be a prescription or recipe and are not necessarily used in the order that follows. For the sake of clarity, I will describe the process as it appears to complement the developmental stages. As with any therapeutic intervention, however, the client's history, diagnosis, transference reactions and unique personality and needs should determine the approach taken to accomplish therapeutic goals. For example, when improvising, some clients will

initially feel safer using words and may experience vocal sounds as more regressive and associated with loss of control. Other clients may feel less exposed in the more open realm of non-verbal singing because words are more specific and definitive. Still others may need even more structure in which case pre-composed songs may be more appropriate, particularly in the beginning phase of therapy.

In the initial “vocal holding” phase the client and the therapist sing in *unison*. Singing together on the same notes can promote the emergence of a symbiosis-like transference and countertransference. This is important for clients who never had a satisfactory experience of merging with an emotionally present, calm, consistent mother. Through a replication of early mother-child relatedness, these clients can eventually internalize a stable sense of self and then gradually renegotiate the stages of separation and individuation. Sometimes sounds and phrases emerge that are reminiscent of the babbling sounds of a three to six month old (Gardner, 1994). The next phase of *harmonizing* creates the opportunity for the client to experience a sense of being separate yet in relationship. *Mirroring* occurs when a client sings her own melodic line and the therapist responds by repeating the client’s melody back to her. Mirroring is especially useful when a client needs support in finding her own voice and/or when new parts of the personality are emerging and need to be heard and accepted. This musical reflection provides encouragement and validation. *Grounding* occurs when the therapist sings the tone or root of the chords and provides a base for the client’s vocalization. The client can then improvise freely and return to “home base” whenever she wants to “refuel” (Austin, 1998, 1999). One client referred to the grounding tones as “touch tones”.

This musical intervention is reminiscent of a typical pattern of interaction between the child and the maternal figure that occurs when the child begins to move away from the mother to explore the environment. In the ideal situation, the mother stays

in contact with the child and supports and encourages her increased efforts to individuate; otherwise the stages of separation-individuation become associated with object loss. Lack of empathy, attunement and of course abandonment and/or impingement during the earlier developmental phases will negatively impact the child's ability to individuate (Bowlby, 1969; Mahler, Pine and Bergman, 1975).

Vocal holding techniques are introduced into the music psychotherapy session in various ways. With a client who is especially anxious about improvising but wants to try, I might explain this method in detail. Usually, however, I give a minimal description or simply ask: "Would you like to try singing about this (person, situation, feeling etc.)? We could improvise or make it up as we go along". I then ask the client if she wants two or more chords. She sometimes chooses the exact chords or gives a general description ("something minor"), but if she has little or no knowledge of chord structure or needs help finding the sound she wants, I might play examples of different chord combinations (major, minor, suspended etc.) and ask for her preference. Occasionally, a client will describe a mood or feeling she would like to evoke and together we search for and find the fitting chords (Austin, 1999). The client may also suggest a rhythm and a piano setting (I use a clavichord that has various settings such as organ, strings etc.). Giving choices and working collaboratively empowers the client and helps to create a safe therapeutic environment.

We begin by breathing together. As previously described, deep breathing is critical in focusing, relaxing and grounding the client in her body. Breathing together begins the process of vocal attunement that continues as the therapist attempts to match the client's vocal quality, dynamics, tempo and phrasing. Being present to the client as an empathically attuned companion may also involve matching her physical movements (for example, rocking together) and making eye contact. Eye contact can reinforce the intimacy engendered by singing together but may be too

intense an experience for some clients and even distracting for others. The most effective way to meet the client's musical-emotional needs, in terms of singing in unison, mirroring, using words or sounds etc. is determined by the therapist's knowledge of the client's history, musical proficiency, general diagnosis, developmental stage, current life issues, transference- countertransference reactions, as well as the musical cues provided in the improvisation. A rudimentary example of the latter, is when Sam, a client who is musically capable of holding his own note, continued to join my tone as I attempted to harmonize with him. I think this musical interaction reflected Sam's need to merge with an idealized object in order to maintain some sense of self-cohesion. Another example is illustrated by Beth, a client who liked to sing but preferred singing alone. As the therapy progressed and Beth found she could express her anger toward me without experiencing abandonment or retaliation, she began to invite me to sing with her. We often harmonized together. My sense was that she now felt she could come closer to me without fear of being engulfed and losing herself.

The therapist is also informed by the client's body language, facial expression and of course her own creative intuition. When the client is aware of her own needs and there is sufficient trust in the therapeutic relationship so that she is unafraid of expressing her preference, much information can be gathered directly in the verbal processing that usually follows the vocal improvisation.

Vocal holding techniques are not the only musical approach I use when working with traumatized clients. It is a method, however, that has proven effective in creating an opportunity for a safe, therapeutic regression in which dissociated and/or unconscious feelings, memories and sensations can gradually be accessed, experienced, understood and integrated. This musical approach often constellates intense transference and countertransference reactions that are essential in repairing arrests in development. Vocal holding initially tends to promote a positive

transference that of the longed for good mother of early infancy and childhood. This highly empathic musical environment is fertile soil in which trust can grow and feelings can be brought to light. If the therapeutic relationship feels trustworthy enough, the traumatized client will begin to differentiate feelings such as grief, terror and rage. At these moments, the therapist and the music have to be experienced by the client as strong and resilient enough to withstand these intense affects. The therapist might alter the music somewhat to reflect the client's changing emotional intensity. This can mean using alternate chord voicings, extending chords (adding 7ths, 9ths, 11ths, 13ths), adding dissonant notes and employing changes in volume, tempo and rhythmic accents. These musical interventions can be made instrumentally and/or vocally.

It is important to stress here, that an advanced level of training is necessary to practice this type of in-depth music psychotherapy. In addition to a master's degree, a doctorate and/or institute training, I believe it is essential for a music therapist interested in working psychodynamically to have his/her own personal psychotherapy and supervision.

Case Example

Vicky, a twenty-eight year old professional cellist, sought out music psychotherapy for what she believed was a psychosomatic illness. Approximately two years ago, after a successful performance, she awoke to find she could not move her right hand. Since that episode, she had been suffering from periodic pain in both her right hand and arm that was seriously affecting her ability to practice and perform. Vicky had been to the best doctors and physical therapists, who found nothing wrong with her. She felt she was losing her "musical self" and she was now convinced the problem was not in her body but in her mind. She was very ashamed of acknowledging this.

Vicky described her family as "normal". Her mother worked full time as a high

school principal and her father had his own medical practice. She had a brother three years younger who still lived at home. Initially, Vicky was reluctant to discuss her family and only wanted to talk about her music and her physical ailment. She appeared to be very bright, serious and responsible, a person driven to constantly achieve, and pursued by a harsh perfectionistic inner critic. She seemed to live in her head and spoke very quickly in a high pitched, monotone voice seldom taking a deep breath or leaving any space for feelings to emerge. I sensed a great deal of anxiety and fragility underneath her confident manner.

Vicky was interested in her dreams and usually brought at least one to each session. The majority of these were archetypal “trauma dreams” (Kalsched, 1996) with images of car crashes, wounded animals and dismembered bodies. I felt the dreams were providing us with a picture of what was happening to Vicky intrapsychically, of the severe split between her mind and her instinctual self.

As the therapy progressed, Vicky came more into focus as a “parentified child” (Miller, 1981) who took care of her emotionally immature and unavailable parents by “holding herself together” and relinquishing her needs and her young, feeling self in the process. I had the sense that her psychosomatic symptoms were related to the shame and guilt she felt acknowledging her feelings and the problems within her family; that it was alright to complain about physical problems but not emotional ones. Intuitively, I felt that her hand was carrying all her unresolved grief and rage. Vicky’s dreams provided information about her unconscious processes but her associations to the material remained on an intellectual level. I felt we needed to access the feelings connected to the dream images. I often use music to work with dreams. Since music and dreams speak a similar language (symbolic), and both directly access the unconscious, it is as if no translation is necessary for the music to resonate in the heart of the dream image and release its affective component.

I thought singing would be an effective way of working with Vicky because she

was not identified with her voice, there was no performance pressure associated with singing and her hands would not be involved. It was a conflict free area. Vicky had enjoyed singing in choirs during her school years but had never improvised using her voice before. During one session I introduced her to vocal holding techniques and when we stopped singing she said, "I felt a chill, like a ghost came into me...I've always been two people, one is independent and rational, the other is all energy and emotion...it's like they came together for a minute." Vocal holding techniques are especially useful when working with dissociative defenses and the kind of mind-body splits so prevalent in traumatized clients (Austin, 1998, 1999). The two parts that Vicky experienced coming together during the singing symbolized a moment of integration that would have to be repeated over and over again to be resolved.

The session that follows took place during our third month of working together. Vicky had just returned from a weekend with her parents. When I asked her how things went she said: "Fine, but my hand started hurting again when I was practicing Sunday." When I inquired further about her interactions with her family and any feelings she had experienced during the weekend, she was vague and changed the subject. She was speaking very fast and in an excited manner but with little real affect. She kept changing topics. I had the thought "a moving target is hard to hit" that she was defending against delving too deeply into any subject. At one point she mentioned a past dream she'd had and I asked her if she'd had any dreams this weekend. She reported the following: "I am at the airport and I'm all excited watching the planes taking off. A plane takes off right in front of me but then turns to the right suddenly and crashes into a building. The plane goes up in flames and I start yelling for help. Men come out of the airport with stretchers and I go with them. There are people badly burned lying on the ground. Then I see a baby. I'm not sure if it's alive or dead. It's all shriveled up."

Instead of asking Vicky for her associations to the dream and/or offering any interpretations, I asked if she would like to try exploring the dream in the music, using two chords and singing. She agreed and came to the piano to sit beside me. I suggested either singing the overall feeling of the dream or an image that felt particularly meaningful to her. She wanted to focus on the image of the baby. I asked her what chords she would like and she said she wasn't sure. I played different combinations for her and she settled on A minor 9 to F major 9. We began by breathing together several times. Breathing helps the client (and the therapist), release excess anxiety, get grounded in his/her body and begins the process of vocal attunement. It also serves as a transition state between speaking and singing. [TAPE EXCERPT].

I played slowly and softly in the middle register of the piano. The tempo, dynamics, repetitious rocking rhythm, chord voicings (suspended 9ths that resolved) and occasional arpeggios seemed to support her voice and create a feeling state that complemented the dream. I liked this music. It felt both soothing to me yet conveyed a particular kind of sadness mixed with longing.

She began singing "ah-h-h", holding the tone – stretching it out. The tone she chose and the open sound suggested a willingness to explore her feelings. I joined her immediately and we started singing in unison. She seemed comfortable with the unison, as if taking in my support and gathering strength by merging or joining with me before beginning to move on her own. She slowly began a descending melodic line, which I mirrored and then harmonized with and then we returned to unison. Her singing voice was softer, breathier and had a more feeling, receptive quality than the music of her speaking voice, which was usually monotone, fast and staccato. At moments, her singing sounded frail and vulnerable to me and seemed to give voice to her young, wounded feminine self. At one point she began an ascending melodic line and I remember thinking she

needed a firm grounding base to support this upward movement. I held a low tone while she ascended. I had an image of a little bird whose spirit had been broken but who kept trying to get off the ground. I believed the baby in the dream was her young, feeling self that was suspended somewhere between life and death. Her singing became dissonant at one point alternating between the flat five and the fifth of A minor 9, and then alternating between the dominant seventh and the seventh of F major. She may have been influenced by my use of suspended 9ths to create tension and resolution. I was playing whole steps to produce this effect, whereas she was singing half steps and creating even more tension by alternately singing tritones. I think the music was reflecting her pain and perhaps her ambivalence about living. The music built and then diminished in volume and intensity as she sang descending and ascending melodic lines. I alternated between unison and harmony sometimes mirroring and overlapping into unison and harmony again. The music felt sad to me and filled with yearning. We “pulsed” together in unison and harmony. The volume and intensity increased as we ascended up the scale. I felt connected to her. I noticed when singing she utilized a vocal range of over an octave, a contrast with the fairly monotone range she spoke in. We descended again and her voice grew soft. I began playing in the high register of the piano and arpeggiating the notes in what felt like a sort of music box sound. She changed from “ah-h” to “hm-m-m-“; a more closed sound which seemed more regressive and perhaps protective. I joined her singing. I saw that she was rocking back and forth and I matched her movement. The singing grew softer and we breathed together and came to a close. We sat in silence for a few moments when the music ended.

I then asked her what she was experiencing. She said, “it’s like we were waking up that dead baby.” She began crying and continued “everyone thinks I’m the happy one and my life should be so good...I feel sad for my brother and my mother, I worry about her.” Vicky began to talk more openly about her family and

how they affected her. Her father emerged as a self-centered person with severe mood swings who could be verbally abusive at times and more loving at other times. Over the weekend he was extremely critical of her playing and told her she should give up the cello and pursue another career. At the end of the session, I reflected how unsafe she must have felt growing up with such an unpredictable parent and how difficult it has to be to express herself in such a critical atmosphere. I believe the “vocal holding” created a nurturing safe environment that enabled Vicky to dialogue with her unconscious so that she could retrieve a piece of what had been lost to her, an image from the depths and the feelings connecting her to the part of herself contained within the image.

Free Associative Singing

Free associative singing is the term I use to describe a technique that can be implemented when words enter the vocal holding process. It is similar to Freud’s technique of free association (1938) in that the client is encouraged to verbalize whatever comes into her head with the expectation that by doing so, she will come into contact with unconscious images, memories and associated feelings. It differs from Freud’s technique in that the client is singing instead of speaking, but more significantly, the therapist is also singing and contributing to the musical stream of consciousness by making active verbal and musical interventions. The accompaniment (two- chord holding pattern or repetitive riff) and the therapist’s singing, continue to contain the client’s process, but the emphasis now is not only on “holding” the client’s emerging self and psychic contents but on creating momentum through the music and the lyrics that will propel the improvisation and the therapeutic process forward. The progression to words and the more active role taken by the therapist promote a greater differentiation between client and therapist. When the therapist begins questioning, reframing and interpreting within the improvisational dyad, the transference and countertransference can become

much more complex. The client may experience the therapist not only as the “good-enough” mother, but in other roles as well (figures from the client’s interpersonal and intrapsychic world).

In its simplest form “free associative singing” involves the client singing a word or phrase and the therapist mirroring (repeating) the words and the melody back to the client. The vocal holding techniques of singing in unison, harmonizing and grounding add additional support and variation. As previously stated, the consistent, repetitive two-chord pattern and the therapist’s vocal support and attunement can relax defenses, induce an altered state of consciousness and facilitate a creative regression in service of the self (Austin 1998, 1999). This improvisational structure continues to emphasize the creation of a predictable secure environment that enables the traumatized client to feel safe enough to express herself and gradually explore her inner world. This two-chord structure is not rigid however. With the movement to words there is often a need for more variations in dynamics, tempo, voicing, arpeggiation, rhythm, accents, rests etc. so that the therapist can use not only her voice and the lyrics, but also music to empathize with the client’s experience, encourage play, and further the exploration of conscious and unconscious material. The spontaneity and unpredictability of play and fantasy can feel chaotic and out of control for traumatized adults. Vocal holding provides a containing play space where spontaneity and creativity can be restored along with a greater sense of reality and wholeness (Dayton, 1997).

Throughout the improvisation, the therapist is making critical decisions about when, how and what to sing with the client. This is especially true when the therapist moves beyond simply mirroring the client’s lyrics and music and begins to provide empathic reflection, ask questions, use repetition to emphasize important words and musically role play significant people in the client’s life as well as parts of the self as they emerge in the therapy. By taking a more active role in facilitating

the therapeutic process and with the use of words, the therapist can help the client understand and make meaning out of what she is experiencing in the present and what she experienced in the past and how these events affected her sense of self. Old, unrealistic self-concepts can be replaced by new, realistic ones resulting in self-acceptance and increased self-esteem.

An intervention that I use consistently and find invaluable, that I previously referred to as an “alter ego” (Austin 1998, 1999), is actually a musical version of the psychodramatic double (Moreno, 1994). When the therapist “doubles”, she sings as the inner voice of the client and uses first person (“I”). Drawing on induced countertransference, empathy, intuition as well as knowledge of the client’s history, she gives voice to feelings and thoughts the client may be experiencing but is not yet singing. When the therapist’s doubling is not accurate, the client can ignore or change the words to fit her truth. This intervention is especially useful for clients working to integrate thinking and feeling or a mind/body split. This split can be observed in clients who can talk about events and feelings without experiencing affect and/or can express intense feelings but have no words to enable them to make meaning out of their emotional experience. Doubling offers an effective way to breathe feelings into words and supply words for feelings. In addition, the naming or labeling of unprocessed trauma material can aid in preventing uncontrolled regression and retraumatization (Hudgins and Kiesler, 1987).

Case Example

Beth, a thirty-five year old artist, originally came to therapy because she felt unable to assert herself in work situations and ended up feeling underpaid and undervalued. She felt her low self-esteem was the problem. As we began to work together it became apparent that Beth suffered from anxiety and depression, sometimes so crippling she had a hard time leaving her apartment. As her story unfolded, it became clear why she had these symptoms. Beth was an only child

whose parents divorced when she was seven. She always felt closer to her father even though she rarely saw him. Beth described her mother as “intellectual” and “strong” but not affectionate and prone to angry outbursts. With time I learned that some of these “angry outbursts” took the form of physical attacks on Beth with whatever was handy (a shoe, a pan etc.) and verbal assaults. If Beth cried the punishment was even harsher.

Beth survived by living in her own world. She would “leave” and go someplace deep inside herself. In this inner sanctuary she would sing and rock herself and tell herself sad stories. Her art also helped her by giving her a creative emotional outlet. Even though she craved attention, receiving it was frightening because Beth associated attention with judgment and pain.

During the first year of therapy, Beth often used a sketch pad and cray-pas to express feelings she had no words for. As trust in our relationship grew, we began to improvise together at the piano and on other instruments. Beth gradually began to find her voice, both literally and symbolically. When I first met her, I noticed she spoke very softly and would gradually speed up while simultaneously fading out at the end of a sentence. As she began to set limits with people in her life and assert her feelings and needs, her voice reflected this change. She sounded stronger and more embodied. We sometimes did breathing exercises together, which also contributed to a reduction in interpersonal anxiety and helped her stay present while speaking to others.

During the third year of our work together, we began to vocally improvise using the holding techniques. The session I will now describe began with a discussion of Beth’s relationship with her close friend, Michelle. Michelle had once again disappointed Beth by canceling plans at the last minute. When Beth told Michelle how hurt she felt, and that this was an ongoing pattern in their relationship, Michelle “exploded” and hung up the phone on her. This painful interaction led to

an exploration of Beth's abandonment issues with her mother.

I asked Beth if she was willing to explore her relationship with her mother in the music by singing together. She agreed and came to sit beside me at the piano (on a separate bench). She said she wanted "dark" chords and then said "minor". I played E minor 7 to A minor 7 (The voicing was 1, 5 in the left hand and 3, 7 in the right to 5,1 in the left hand and 7,3 in the right) in a medium to slow tempo. We began by breathing together and then singing in unison on "ah". I felt Beth was getting in touch with her resources, her inner strength and the qualities that helped her survive difficult times. Her face softened and her shoulders relaxed. Her voice became steady and grew stronger as we continued singing. She appeared to be grounding herself in her own body and feeling the support available in our connection. After a few moments she sang, "I'm not the person I was" and I mirrored the words and melody back to her. She continued, "the person you made me think I was". Again I reflected her words and melody while matching her volume, vocal quality, and phrasing. She repeated these two phrases and then sang, "I'm not ugly, mother, I'm not ugly." She repeated this phrase and then said, "I'm not a child anymore". I mirrored her words and joined her in harmony on the word "child" which we held for a measure. Beth then increased the volume and intensity of her singing and doubled up the time in her phrasing, perhaps to express her excitement and/or her feelings of empowerment. She sang, "I am a woman, a strong woman, a flower, a tree". She held "tree" and repeated it so I was able to support this affirmation by harmonizing with her.

She was singing in a range of less than an octave. Her melodies included many ascending fourths and fifths. My association to this music was that Beth was taking a leap and landing on solid ground. She then sang, "you didn't kill me" and I got chills. I left a pause (I'm not sure why, it might have been my countertransference). She then sang "I wish I could say you're not my mother anymore. I'm my own

mother". I felt sad at this point. I also felt she was singing with a greater depth of feeling. I sang "I feel sad" (using my countertransference and singing as her "double"). She picked this up and sang "I feel sad" and her voice was soft and breathy. She sang "I never had a real mother." I mirrored this, joining her in unison on "mother" and then sang "I wanted a mother" ("doubling" her again). She repeated this phrase and we sang it over and over in unison, harmony and overlapping mirroring. I moved my left hand and played lower in the bass of the piano to support the intensity of our singing. I played eighth note triplets in my right hand to match her energy when she began singing louder and fuller.

Beth then sang "you hurt me". Again I repeated this and we sang the phrase over and over again. It felt as if the words were sinking in deeper each time we sang them. I sang, "I won't let you hurt me anymore" ("doubling") and she repeated this and added, "I can say NO!" We sang this phrase together in unison and harmony going up the scale melodically and building dynamically. Then she paused and I went back to singing "ahs" to keep "holding" and supporting her. After a while Beth came back in and sang, "How could you not see a child so full of love", in a voice that sounded vulnerable and childlike. I sang, "You never saw me". She repeated this and went on, "you never saw my drawings...you never saw a little girl". I echoed her words and melody and then sang, "so I went away". There was a brief pause and then Beth sang, "but now I'm back". At this point in the music Beth began crying softly. I slowly brought the music to a close singing on "oo" to soothe and comfort her. I was feeling very moved. I was also teary. Perhaps I was soothing myself as well.

Afterwards we briefly processed what had transpired in the music. Beth said, "you sang a lot of things I was feeling but didn't know, couldn't find the words for ... I have come back, at least for today."

Conclusion

We come into the world as helpless infants, dependent on our mothers and other caretakers to meet our physical, emotional and psychological needs; dependent on them for our very existence.

When these needs are not met, when a child cries and there is no answering voice, or the sound that returns confuses or obliterates, then the ability to play, explore, learn and grow is compromised. How do we find our own sounds, movements, feelings and sensations? How do we discern our own voices and grow into our own unique identities, without a safe environment and a consistent empathic presence to hold us and let us go?

We can blame our parents, but they had parents who had parents...The cycle of abuse, neglect and just plain unconsciousness will continue until we make an effort to stop it.

I believe the primary healing element in music psychotherapy is the relationship. The self cannot develop without a relationship to another self. Traumatized clients have difficulty trusting and forming healthy bonds with others. Music, and vocal holding techniques in particular, provide a fluid yet stable structure, a safe dependable container for vocal play and the expression of feelings and needs. Singing together can bring about physical, emotional, psychological and spiritual connection between the client and therapist and the client and his/her core self.

Adult clients who suffer from the symptoms of childhood abuse, neglect, emotional deprivation and inadequate parenting require a method of psychotherapy that can address preverbal wounds and the unmet dependency needs of early childhood. Music therapy is one very effective way of working with this population.

Music is “medial” (Austin, 1996). It flows easily between the conscious and unconscious worlds, bringing with it feelings, images and associations from the personal and collective unconscious and a creative means of expressing them.

Vocal holding techniques can induce a therapeutic regression in which early mother-child relatedness can be replicated and the client can have a reparative experience by renegotiating crucial junctures where the relationship with the primary caretaker was ruptured.

Singing, being physically based, enables a severely dissociated client to re-enter her body and access and give voice to what was previously inexpressible. Through free associative singing, the music allows the words to become embodied and linked to feelings so that clients can more easily heal splits between thinking, feeling and sensation.

Trauma survivors are used to feeling misunderstood, lonely and isolated. Singing can break through the walls of isolation but requires courage on the part of the client and the therapist. It takes courage for the client to work through the shame and allow him/her self to be seen as needy and vulnerable. It takes courage for the therapist to stay present and available while companionship the client down dark, empty corridors and into rooms filled with violent and painful memories.

The music shared deepens the relationship. It also provides a safe, intimate space where the authentic voice of the client can come forward and experience empathy and understanding, and gather strength and hope in the process. In the music there is a meeting, a coming together of two realities that create a third one. In the silence, in the words, in the music, the client feels as if the therapist is singing. "I too, have lived through such pain and believe it can be tolerated, understood and accepted. I am not afraid and I want to be here with you...now."

For my mother, who inspired my passion for this subject and my clients who have helped me to learn how

to help them.

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