

**EXPLORING REVERIE:**  
**An exploratory inquiry into the instances of reverie and their occurrences  
within a particular music therapy case study and its improvisational work**

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## PREFACE

I am re-presenting the abstract which is in the cover page of this thesis, to clarify the scope of the thesis which follows:

One of the main concepts within psychoanalysis is that there are three levels of consciousness: the unconscious, the preconscious and the conscious. The aim of this work is to discuss and analyze a process which deals with all three of these states of consciousness on different levels, called “reverie”, as experienced within the music therapy setting.

This thesis initially looks at what has been said so far about reverie, and the goal of this work is to describe the possibility of thinking back retrospectively to moments in music therapy which when experienced can seem hazy and blurry, “dream-like”. The research will be conducted through a qualitative analysis of data collected during 18 music therapy sessions which were video and audio recorded. The study will consist in the exploration of reverie within the therapy process; the method employed is Therapeutic Narrative Analysis. The question that ideally will be answered in this study is whether or not experiencing reverie will have had an effective result on the ability of patient and therapist to access their unconscious contents.

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## 1. INTRODUCTION

The music therapy process is a delicate yet powerful one. It is delicate because it seeks to uncover some of our most inner contents, which are often well hidden by defense mechanisms. These contents are subjective and not easily recognizable objectively, or scientifically measurable, but still valuable. In considering a chapter by the phenomenologist M. Forinash, “Phenomenological research” (found in B. L. Wheeler (ed.), 1995, *Music Therapy Research: Quantitative and Qualitative Perspectives* (pp.367– 387)) two other authors, Aldridge and Aldridge argue:

Phenomenologists assume that all things start with the world as experienced, the world as it is lived and perceived before it is abstracted into theory or explanations. Experiences are a fact in our world; they exist and therefore do not have to be categorized as true or false, valid or invalid. They are worthy of investigation simply because they exist (Aldridge and Aldridge, *Melody in music therapy: A therapeutic narrative analysis*, 2008, p. 57).

Another theoretician, Bruscia, in the 1989 edition of *Defining Music Therapy*, described the music therapy process as powerful because “(it) is a systematic process of intervention wherein the therapist helps the client to promote health, using musical experiences and the relationships that develop through them as dynamic forces of change” (as cited in Bruscia, K. E. (2013), *Defining Music Therapy*, p. 21).

I will try to show in this thesis how music therapy can enrich one’s life and help patients change. There are ways in which music therapy sessions are similar to more traditional therapy sessions, and others in which they differ. Transference and countertransference are elements that music therapy shares with any other kind of psychoanalytic therapy, while symbolizing through music is a unique process in music therapy.

In this thesis I intend to examine a process that has been defined as “reverie”, which I believe to be one of the core aspects of both psychoanalysis and music therapy, although it takes

place differently within the two contexts. Like transference and countertransference, reverie is intangible, ephemeral, and difficult to define, which is what makes it so interesting.

This thesis is divided into seven sections: the first and second are a review of some relevant theoretical writing; the third describes the methods which emerged in the course of the fourth and the fifth part of the thesis; the fourth part is a description of a specific case study and the fifth part analyzes the themes that developed in the course of the case study. Section six and seven will include my conclusions and insights.

## **2. KEY CONCEPTS AND THEORETICAL FRAMEWORK**

What exactly *is* this process called “reverie” and how can it be used in the context of Music Therapy? Also, can we affirm that reverie occurs somewhere between the unconscious and preconscious states? Or should it be said to belong more to the realm of the unconscious? And do musical improvisation and reverie somehow take place in similar realms of consciousness?

Although this process is at times something that is easier to experience than to define, however I will try to suggest some answers to these questions within this thesis.

### **2.1 Some theories on reverie in psychoanalysis**

#### **2.1.1 Dreaming and the mother-child analogy**

The Oxford dictionaries define reverie as a state of being pleasantly lost in one's thoughts, a day-dream (Reverie [Def. 1]. (2010). Stevenson, A. (Ed.), Oxford Dictionary of English.: Oxford University Press. (3rd Ed.)). Even though obviously the term has a much more layered and multi-faceted meaning when applied to the therapy setting, the concept of dreaming is still essential to keep in mind when talking about reverie. According to Ogden in his article “On holding and containing, being and dreaming” (2004), reverie can be defined as being an aspect of conscious experience which is profoundly interrelated with unconscious experience, as indeed is the manifest content of dreams:

The quintessential manifestation of the psychoanalytic function of the personality is the experience of dreaming. Dreaming involves a form of psychological work in which there takes place a generative conversation between preconscious aspects of the mind and disturbing thoughts, feelings and fantasies that are precluded from, yet pressing towards conscious awareness (the dynamic unconscious) (Ogden, 2004, p.1355).

Though Ogden is among the psychoanalysts who have dedicated most time and effort to developing the idea of reverie, the term “reverie” was first introduced within the psychoanalytic field by W. R. Bion in three foundational books: *Learning from Experience* (1962), *Elements of Psycho-Analysis* (1963), and *Transformations: Change from Learning to Growth* (1965).

In 1978, Bion, in the São Paulo clinical seminars, in: *Clinical seminars and four papers*, p. 131-222), discusses the importance of the state of dreaming in everyday life. Ogden, in discussing this idea, says:

Though all three of these types of thinking -unconscious dreaming, preconscious reverie and conscious reflection - are involved in the containing function of the mind, Bion views the unconscious work of dreaming as the work that is of primary importance in effecting psychological change and growth. Bion urges the analyst not to be ‘prejudiced in favor of a state of mind in which we are when awake [as compared to the state of mind in which we are when asleep]’ In other words, for Bion, “the state of being awake is vastly overrated” (Ogden, 2004, p.1356).

We can conclude from the discussions above, that what makes reverie so important and unique is that, like dreams, it is a bridge or a dialogue between the unconscious and conscious thinking. This important distinction between unconscious, preconscious and conscious thinking (and between primary and secondary process) and its relation to music therapy has been analyzed aptly in the book *Musical Imaginations* (Erkkilä, J., Ala-Ruona, E., Punkanen, M., & Fachner, J., (2012)) which has informed my understanding of these distinctions.

Bion has influenced several other writers who considered and further developed his ideas. One of them, E. V. Våpenstad, in “On the psychoanalyst's reverie: From Bion to Bach” (2014) tells us that Bion posited a parallelism between the mother-child relation and the relation that occurs between the therapist and patient. Bion said that the child and the mother, united in a state of reverie, is the prototype of the psychoanalytic relationship. In the same text Våpenstad comments on Bion’s description:

his [Bion's] starting point was a description of how the mother is able to keep her infant in mind by working both consciously and unconsciously on her mental impressions of the child and of the impact the child has on her. The mother's mental impressions do not always concern what is actually going on in the immediate interplay with the child; often the mother's mind is filled with thoughts, pictures, associations, sounds, and impressions with very different content (Våpenstad, 2014, p. 162).

Then Våpenstad goes on to say:

Reverie is a mental state in which the mother, for instance when she is nursing her child, is completely absorbed in her own mind and has left the real world. Yet at the same time, she is fully concentrated on every psychical signal from the child. This state of mind can be described as a sort of daydreaming or absent-mindedness (Våpenstad, 2014, p. 162).

In Bion's theoretical terms, the infant projects his still disorganized and unprocessed mental contents (which Bion refers to as *beta elements*) onto the mother, whose mind acts as a "container" for the child, processing the thoughts and giving them meaning, consequently returning them to the child as thoughts that are easier to process and to deal with mentally. According to Bion (*Elements of Psychoanalysis*, 1963, p. 27), a "good enough" mother is a mother who uses what he called the "alpha function" to return and transform the child's beta elements into alpha elements. The alpha function, in its giving meaning to unprocessed mental contents, is in fact the process of reverie.

Using Bion's conceptualizations, Ogden further developed these ideas. For example, he developed and expanded Bion's concept of the mind *as a container* (Bion, 1962, p. 90) both the mother's mind and by analogy the therapist's, in particular in connection with the concept of reverie:

The 'container' is not a thing, but a process. It is the capacity for the unconscious psychological work of dreaming, operating in concert with the capacity for preconscious dreamlike thinking (reverie), and the capacity for more fully conscious secondary-process thinking (Ogden, 2004, p. 1356).

The mother-child relation can also be significant when thinking about many processes happening within the music therapy setting. Research has shown that infants can already perceive sounds while still in the womb (DeCasper & Spence, "Prenatal maternal speech influences newborns' perception of speech sounds", 1986). The mother's voice and her heartbeat are the first elements that the child perceives as other than himself. Furthermore, when talking to her infant, the mother at first uses a language which has been called motherese: this oversimplified, "cooing" talk, can be considered as not entirely symbolic as verbal language is, but rather, pre-symbolic. This type of speech has many parameters in common with music.

It seems clear that Bion's analogy (mother-child as therapist-client) holds true in both traditional psychoanalysis and in music therapy. A mother's attitude of reverie towards her child and her ability to attribute meanings to the child's unsaid needs is analogous to music therapy, where the music and the therapist help the client to find a meaning for her inner world, and to express her emotions more clearly. This idea sheds light on the ways the therapist can ideally interact with her client.

## **2.2 From psychoanalysis to music therapy**

In making an analogy between music and psychoanalysis, Ogden cites Debussy.

Debussy felt that music is the space between the notes. Something similar might be said of psychoanalysis. Between the notes of the spoken words constituting the analytic dialogue are the reveries of the analyst and the analysand. It is in this space occupied by the interplay of reveries that one finds the music of psychoanalysis (Ogden, *Reverie and Interpretation: Sensing Something Human*, 1999, p. 107).

Taking this concept further, what is the difference between reverie in psychoanalysis and reverie in music therapy?

Does the interplay of reveries take place differently in psychoanalysis and in music therapy? Perhaps before proceeding to a consideration of the answer to this question, it will be useful to clarify the concept of reverie as it actually unfolds in both psychoanalysis and in music therapy.

### **2.2.1 Reverie in psychoanalysis: A case study**

Among some clinical accounts of reverie, there is a case study which seems of particular importance in attempting to make the idea of reverie in psychoanalysis clearer.

The case study already mentioned above, entitled “On the psychoanalyst’s reverie: From Bion to Bach” (Våpenstad, 2014, pp. 161–170) is an excellent example of what reverie actually is, how it unfolds, and how it contributes to the therapeutic process.

The study examines some focal events within a psychotherapy setting with a 5-year-old patient, a little girl who suffered from early trauma. She was not able to feed properly as a newborn thus risking starvation, and she subsequently witnessed, at age 3, the death of her younger brother and her father’s desperate attempts to revive him.

The therapist says that towards the beginning of the therapy an aria from a Bach sonata arose strongly in the foreground of his mind, but because he wanted to find an analytic interpretation of the situation, he initially pushed it aside.

After finally giving in to the experience of the Bach aria, upon further exploration of the sonata, the therapist uncovers details regarding it which darkly and in a surprisingly dramatic way relate to the child's past and her troubled experiences.

The aria begins: "I eat with joy my scanty bread...". Although the therapist does not make this interrelation explicit in his article, we can see that this sentence is powerfully connected to the experience of the patient not having had enough food in her infancy. Furthermore, what the therapist recalls about the facts of Bach's life surrounding the event of writing this aria include Bach's frequent experience of the death of a child. He also lost his first wife, Maria Barbara, abruptly in 1720. With his second wife, Anna Magdalena, Bach conceived 13 children, but only six lived beyond early childhood. Between 1723 and 1733, Anna Magdalena gave birth to 10 children, seven of whom died in childhood.

When Bach's music leaves the therapist's mind and finally enters the psychoanalytic stage of the therapy setting, the healing phase of the process can at last begin to take place. A related Bach fugue comes to the therapist's mind during a session and he hums the fugue and takes a piece of paper to write down a note to himself about it. The patient then asks him about what he has written down. The following exchange between them takes place:

"It was just this melody that I wanted to remember." "Was it 'Ja vi elsker'?" ["Yes, we love;" the Norwegian national anthem], she asked. "Was that the melody that you were humming?" "No, it was someone playing an organ," I answered. "Organ," she said. "They said at the hospital that they play organ in heaven. My brother is there now; maybe he is fine up there with the organ and everything?" (Våpenstad, 2013, p. 169).

We can actually see and sense for ourselves here the reality and the actual possibility of healing and hope that experiencing reverie can bring forth within the therapy setting both for the therapist and the child.

### 2.2.2 Getting closer to reverie and music therapy

It is important for the therapist to foster and create an interpersonal space, “a specific, holding environment between the therapist and client, [...] called a potential space” (as discussed by Erkkilä et Al., 2012, p. 417). It is within this emotional and psychic space that reverie can occur.

It is helpful to add to this concept Ogden’s analogous theory that within the therapy setting there is an intersubjective area consisting of the emotional contents of analyst and analysand, which he calls the “analytic third”. This is an area within the field of therapy, where the line between the inner contents of patient and therapist is blurred.

As we will see later, when looking at reverie in music therapy, music used within therapy can be seen as something similar to this blurred interpersonal area which Ogden referred to. Thus, in a way, music can be seen as a third object in therapy, and also as a third entity.

In music therapy both verbal and musical communication are employed. The musical improvisations and activities in the music therapy setting facilitate the unfolding of reverie. Music helps us to get in touch with pre-verbal emotions and symbols that we can become more aware of while playing. We can associate symbols to music, and to the emotions it brings forth in us. But to give these symbols and emotions a name, we need verbal language. For there to be a bridge between unconscious pre-verbal contents and the language of what is known, one must be able to speak about them. Therefore, it is through verbal reflection that we become more aware of what arises in us while engaged in music. The music therapy session, when successful and complete, perfectly combines moments of reverie and the process of re-appropriating them through more conscious verbal reflections. However, because reverie in music therapy is such a delicate and wavering event, as is dreaming, it can sometimes be difficult to make the bridge and approach it consciously. Thus in music therapy patient and therapist attempt to reclaim transient insights which may have

slipped back into the unconscious by reflecting together verbally upon any symbolic content or images that may have emerged during the improvisations. It is during these more verbal times that one can “reawaken” from reverie and try to gain meaningful insight into one’s own inner contents. The difficulty in gaining this conscious insight into reverie is aptly described by Ogden:

One must struggle to “hold on to” one’s reverie experience before it is “reclaimed” by the unconscious. [...] A reverie that has at one moment seemed fully available to conscious awareness will frequently at the next moment seem to have “disappeared”, leaving only a nonspecific residue of feeling in its wake” (Ogden, 2001, p. 21).

### **2.2.3 Reverie and the musical interplay: a case study**

Much has been said about reverie in psychotherapy but very little has been said about reverie when applied to music therapy. One of the first to talk about reverie within the context of music therapy was De Backer in his dissertation on music and psychosis: *Music and Psychosis: The transition from sensorial play to musical form by psychotic patients in a music therapeutic process* (2004).

De Backer also talks about the bridge and fluctuation between an unconscious level and a more conscious one. In other words, the therapist faces the formidable task of plunging into his own “reverie” in order to get in touch with the deeper reverie of his patient while retaining his ability as a therapist to lead the patient to his own insights. De Backer offers the following useful guidance:

How should a music therapist listen to the patient? The music therapist should listen to the patient with reverie. We understand the concept of reverie to indicate that the therapist, just like the mother, gives meaning to a situation which feels chaotic to the child. With reverie the mother puts the particular experiences of the child into a kind of order; for example, she will know instinctively if the baby is hungry or not. [...] It is the task of the music therapist to listen and communicate with the patient in a similar way. [...] This calls for intuition and sufficient experience on the part of the therapist. [...] The music therapist [...] needs to fluctuate sensibly between the intuitive, unconscious level and the conscious level (De Backer, 2004, pp. 76-77).

De Backer also refers to the conscious level as the “adult level”. And points out the necessity of reaching this level in order to understand the patient’s intuition. As he says:

The music therapist must always be able to let go of the reverie attitude and swiftly return to an adult level. He must be able to fluctuate from the intuitive, subconscious level to the more conscious. This skill is necessary in order to reflect and to know exactly what the patient is expressing (De Backer, 2004, p. 66).

The more unconscious level of reverie may be understood as regression or partial regression. The level of reverie of the music therapist when music is the medium becomes simply a means of treatment.

The partial regression of the music therapist when music is the medium, is simply a means of treatment. In this way the music therapist finds a medium in the patient's regression which permits childish experiences at a symbolic level and teaches him to live with them (De Backer, 2004, p. 66).

De Backer has found that states of reverie take place when patient and therapist are playing together and the therapist accompanies the patient in musical improvisation, in particular, when the player recognizes that the music is an object that no longer coincides with himself. This moment becomes the transitional space created in therapy when the interpersonal interaction of client and therapist results in a blurring of the inner contents of client and therapist. This allows for the patient to express his feelings and project them onto the therapist, and for transference and countertransference to occur as well. Thus, in music therapy the use of music facilitates the unfolding of this transitional space and of the reverie which can occur within it. De Backer describes this situation as follows:

For instance, at the moment anxiety is expressed through playing one is distanced from it - there is a separation from this anxiety. Expression no longer coincides with what is expressed and there is a symbolism. Out of an imaginary oneness a relationship with something exists, in that the anxiety itself is being played and there is no longer only a 'someone' who is anxious. There is a division between the subject who is suffering and the subject who is playing his suffering (De Backer, 2004, p. 64).

To illustrate how music represents and symbolizes feelings, so that the client is able to look at these feelings as something outside of himself and to distance himself from them, and subsequently re-appropriate them newly, De Backer introduces the useful analogy of a child playing with a teddy bear; the teddy bear represents his mother and acts as a "transitional object". This means that the child can project his feelings towards his mother onto the object, and in this way he can see and deal with these feelings. At the same time, he is entirely aware of the fact that his mother is elsewhere, i.e. not the teddy bear; this allows him to distance himself from the mother. In the context of the music therapy setting, in this analogy, the teddy bear represents the music, while the mother represents the feeling of anxiety, in the particular case he is discussing.

De Backer argues that music therapy is unique in that reverie unfolds as therapist and client are both actively engaged in a creative activity. Therefore, music has the advantage of the patient not feeling "left alone", because the musical interplay takes place as they play together. The music therapist can actually *be* with the patient, as he accompanies him in musical improvisation, and this accompaniment builds a basis for trust, in that the therapist shows he is there for the patient.

What is important here is that the music therapist can join in the playing. Through it, in a form of 'reverie', the therapist gives expression to the musical play of the psychotic. Reverie here is concerned with the attitude of the therapist who gives form to the chaotic, unbearable experiences of the patient, as defined by Bion (1967). Music therefore has the advantage that the patient need not be alone in his chaotic experience. The music therapist has the means of being with the patient without having to exclude him. He achieves this not only by his attitude and listening but also through his empathic accompaniment. (De Backer, 2004, p. 64).

In support of his thesis, De Backer presents a case study and several clinical vignettes which shed light on the case. His client is “Adrian”, a 17-year-old adolescent diagnosed with child psychosis. After a preliminary meeting with the patient, De Backer decided to use a psychoanalytically-oriented music therapy model with sessions that would last 45 minutes each. In session one, the first thing Adrian did upon entering the room and sitting down at the piano was to play the first few notes of Fur Elise, and to ask the therapist to teach him to play this piece of music. Because music therapy is different from music education, the therapist at first had some hesitation in yielding to this request, but as the sessions progressed the meaning of such “teachings” began to become more clear, and he decided in fact that this would be important for the therapy’s progress.

It was in particular thanks to an improvisation and the reverie which occurred within it, during the assessment stage of the therapy, that certain conclusions came to him. Interestingly, these came to him while the therapist was waiting for the patient to arrive. In fact, De Backer considers reverie as an important part of the clinical context, during the actual therapy session, and also before and after it, when the client is in fact *absent*. He says that the therapist can improvise freely in a *reverie* state to remind himself of how he felt during the previous sessions, but also to process and elaborate what may have happened and what may happen in the therapy. Specifically, in the case of Adrian, towards the very beginning of the therapy, the therapist improvises musically around the idea of the patient’s absence and the risk of his not coming to the session, or to quitting the therapy entirely. By using the reverie stance he adopted whilst playing, certain extremely illuminating insights came to him during this particular improvisation.

Whilst improvising, the therapist had the image that he needed to give Adrian more space and to accept and respect his fears and limitations. He had an insight that Adrian saw the learning of ‘Für Elise’ as the essence of music therapy and that Adrian could grasp this as an opportunity to control the therapeutic framework (De Backer, 2004, p. 188).

Further along, at the beginning of the working phase of the therapy, we get a vivid and concrete example of how the build-up of the therapist's efforts to *be with the client*, to teach him Fur Elise and find a therapeutic meaning within this "teaching" process, and to play first for him, and then with him, in a reverie mode, indeed helped Adrian to find his own musical voice; it did so by meeting Adrian's need to find a musical form, a musical form in opposition to what Backer calls the *sensorial play* of clients with psychosis. *Sensorial play* is repetitive, mechanical and seems to have no beginning and no end, that is *no form*. In Adrian's case, this is what De Backer refers to as his *ostinato* (which incidentally in Italian can be translated as the word "stubborn"); and it is this theme which the therapist himself improvises on in this instance:

Making use of Adrian's own theme (the *ostinato*), the therapist improvised music which confronted Adrian with a desire or longing for a musical form of some sort. It was a musical reverie to which the music therapist added this desire for form. It was also a musical reverie with another kind of desire, that of actively exploring the unknown (De Backer, 2004, p. 204).

To better explain this therapeutic moment, De Backer turns to Bion and his mother-child analogy referred to earlier, pointing out Bion's attempts to define the elusive nature of the therapeutic moment by comparing "the reaction of a mother to a crying child, where the fragmented and chaotic responses of the infant are responded to [by] the mother's form-giving input" (De Backer, 2004, p. 204).

What happens after the therapist plays in a reverie mode for the client, elaborating upon Adrian's *ostinato*, (a reverie mode in which he presents a desire for musical form and a desire for "exploring the unknown"), is astonishing. It is something that has been waiting to happen, a culmination in the therapy, the beginning of the actual working phase. It is the consequence of the therapist and client's patiently waiting in many previous therapy sessions. Therapist and client actually change places at the piano, and it is now Adrian who finally begins to improvise melodically, letting himself express himself with musical form, venturing out from the incessant, apparently unending (i.e. formless) *ostinato*. De Backer describes the magic moment;

Adrian and the therapist changed places at the piano; the therapist sat to the left hand side and took over Adrian's ostinato. Adrian started to improvise a melody and his music was related to the reverie-play developed by the therapist in the previous improvisation. Here, Adrian dared to improvise. His hands no longer slumped on the keys he was playing independently and he really appeared to be engaged authentically in the music. The therapist played the ostinato as soberly and carefully as possible and limited himself to subtly supporting Adrian. He was surprised and happy that Adrian could sustain this music for so long (De Backer, 2004, p. 204).

## **2.3 Additional helpful perspectives on reverie: The couch and reverie; “Negative capability” and the proper limits of reverie as discussed in works of Ogden, Keats and Ferro**

Other writers have contributed to the understanding of reverie. In this section we will consider three of them.

### **2.3.1 The couch**

The following is an attempt to try to understand some of Ogden's theories concerning reverie from the music therapy perspective. According to Ogden, the presence of the couch within the psychoanalytic setting is a very important aspect of the therapy process. When lying on the couch the therapist is out of the patient's view, and this allows for the patient to access his unconscious more easily, enabling him to focus on his inner contents unhindered by the sight of the therapist, thus making reverie more likely to take place (Ogden, 1999, pp. 114-115). Of course, one must take into consideration that Ogden is referring to a more “traditional” psychoanalytic setting and does not have music therapy in mind. Within the music therapy setting the presence of a couch would quite differ in effect from a couch used within a verbal only psychotherapy setting.

However, it is true that in receptive music therapy, listening to music whilst lying down is often implemented as an activity, which can help the patient to access and release inner

contents, images and fantasies. For example, in several of the internships being conducted currently at our department, therapists in training have offered patients the chance to lie on a vibro-acoustic chair (to learn more about this type of chair, see: “An introduction to vibroacoustic therapy and an examination of its place in music therapy practice” by Hooper, 2001) while listening to music of their own choice. In these cases, although the setting is still quite different from the one Ogden refers to, it would be interesting to explore whether or not the therapist being out of sight could make a difference in the therapies being practiced today. This might be an interesting subject for another paper. One important consideration in this regard might be that a more relevant issue in therapy is not whether the therapist is *physically* out of sight, but rather whether he can stay in the “dialectical” background, in a symbolic sense, rather than a material one.

### **2.3.2 The importance of negative capability, an idea borrowed from Keats by Bion, and reverie - its proper limits: Ferro**

In fact, another element in psychoanalytical theory and practice is the ability of the therapist to exercise her “negative capability” – a kind of patient waiting for inspiration. This concept was first conceived by the author Keats in his letter to his two brothers written on December 21<sup>st</sup>, 1817: “...it struck me what quality went to form a Man of Achievement, especially in literature & which Shakespeare possessed so enormously- I mean Negative Capability, that is when Man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after facts and reason...”

In discussing the ideas of Bion, another writer already mentioned above, Våpenstad, points out:

What Bion asks of the analyst is to put aside this incessant seeking for objective facts and instead try to be like the artist who can endure long periods of not-knowing in waiting for new inspiration (what Bion, borrowing from Keats, called “negative capability” (Våpenstad, 2014, p. 163).

Though it intuitively may seem that putting negative capability into action does not require much effort, because it is literally the act of *waiting, doing nothing*, in my own case study, described below, I discovered how difficult it was to actually put into effect.

Still another writer, Ferro, in the case history presented in his article “Trauma, Reverie and the Field” (Ferro, 2006), emphasizes that reverie can play a crucial role in therapy, if one knows how to put it to use correctly. Ferro underlines the fact that he does not immediately share his interpretations with the patient as soon as they emerge; rather he waits until the therapy process reaches the end of its first year. He writes that it can be more beneficial in therapy if the analyst is able to refrain from making too many disclosures of his own interpretations, but instead immerses himself in a state of reverie which is dream-like yet at the same time susceptible to subsequent mentalisation.

## **2.4 Conclusion**

It is the intention of this thesis to explore some of the ideas that have been briefly mentioned in this theoretical review of some thinking in the area of reverie. So far the review in this section has proposed to try and depict some of the many concepts that can be associated with the term reverie in psychoanalytic and in music therapy. Following is a description of the methods that will be applied in this particular research project to extend somewhat the existing knowledge concerning the idea of reverie within music therapy. The object of the case study that follows is to illuminate further the theoretical insights which have been briefly sketched out above.

### **3. RESEARCH GROUP AND INDIVIDUAL CASE STUDY**

#### **3.1 Description of the research project: Correlation between heart rate variability and reverie**

The research group lead by Professor Erkkilä which I joined in the Spring of 2015 originally gave birth to this thesis. The aim of this research group (which is still ongoing) is to test whether or not certain interventions applied before a music therapy session can foster creativity and expressiveness in the client and therapist, during individual sessions and throughout the whole therapeutic process.

In particular, the research focused on the correlation between heart-rate variability measures and creativity, expressiveness and the overall constructive development of the therapeutic process in the research of Olivier Brabant (a music therapy Phd researcher at JYU, and himself part of Professor Erkkilä's research group). Brabant is studying how optimum heart rate variability measures attained through certain appropriate breathing techniques can affect creativity in the client. To test the validity of Brabant's theories, regarding the correlation between paced breathing and heart rate variability and creativity, the research group has been implementing and applying these techniques to several therapy pilots. These can be brief or somewhat longer (12 session or 20 session) therapy processes.

Each session lasts one hour, with Brabant's interventions lasting 15 minutes at the beginning and the 45 minutes of the remaining time being the actual music therapy session. Paced breathing, a calibrated and individualized breathing exercise that has an influence on heart rate variability. As has been demonstrated outside of the context of music therapy, both immediately and in the long run, this intervention has a variety of positive effects on health and wellbeing. In my portion of the pilot, where I acted as the music therapist, Brabant participated at the beginning of the sessions, leading the paced breathing and the control interventions. He also gave the client a mood test throughout each session. The client took the

test once at the beginning of the therapy session, then right after the ten-minute intervention, and finally at the end, just before leaving the music therapy clinic room.

The test had three separate scales, each one evaluating a different affect value, and made out of two opposite valence pairs; the first being happy - sad, the second excited - tired, the third dominant - passive.

The music therapists in the pilots are research group members, completing their studies as music therapists in training at the Master's level at JYU. The research and the case study presented which follow were a part of this entire research group process and describe the pilot in which I acted as the music therapist. In this case study, which consisted of 18 sessions, every even (2, 4, 6...) session started with paced breathing, and every odd (1, 3, 5...) session had a control intervention at the beginning, which involved ten minutes of the client sitting in a vibro acoustic chair with the chair's vibrations set at a specific and constant setting. I chose to focus specifically on whether or not the breathing intervention facilitated the unfolding of reverie. Though I initially observed that the paced breathing definitely led to a greater depth and learning process, it did not always seem to be possible to directly link the paced breathing to the occurrence of reverie. I wanted to explore whether the linked process indeed lead to a more successful unfolding of the reverie state. In fact, after participating in the pilot and watching the sessions afterwards, I determined that such a link could be made.

### **3.2 Evolution of the case study**

My research process underwent several transformations, largely because of the nature of reverie. Originally my case study was not going to be about the pilot in which I participated, but rather about a different pilot (of 12 sessions) of the same research group, where another research group member acted as the music therapist. The client for that pilot was a 24-year-old female student.

Reverie is a delicate, elusive and subjective process. It occurs in an interpersonal space, shared by therapist and client and it is therefore difficult to describe and observe in any therapeutic context. This is even more the case when observing other therapists and much easier to observe in ourselves. Therefore, my focus shifted and I chose to analyze several sessions from my own internship within these pilots. This also required a change in methodology.

### **3.3 Transformation of my methodology; From Content Analysis to Therapeutic Narrative Analysis**

My original methodology was to make a qualitative content analysis of data collected throughout 12 sessions of an individual music therapy process, video and audio recorded, that would be the basis for the case study for this thesis. The case study was to comprise a brief music therapy process taking place in the Spring of 2015. Additional data collected through an interview, would consist of a qualitative self-report where the therapist involved in the study would answer semi-structured open-ended questions.

The SAGE Qualitative Methods Dictionary by L. Given (2008) defines interviewing as "a conversational practice where knowledge is produced through the interaction between an interviewer and an interviewee or a group of interviewees" (p. 470). In semi-structured interviews, such as the ones that were going to be implemented for this research project, "the agenda is set by the researcher's interests yet with room for the respondent's more spontaneous descriptions and narratives." (p.470).

I would also use content analysis, which seemed perfectly suited to this sort of research. Here is a general definition:

Qualitative content analysis is sometimes referred to as latent content analysis. This analytic method is a way of reducing data and making sense of them—of deriving meaning. It is a commonly used method of analyzing a wide range of textual data, including interview transcripts, recorded observations, narratives, responses to open-ended questionnaire items, speeches, postings to list servers, and media such as drawings, photographs, and video (L. Given, 2008, p. 120).

According to the SAGE Qualitative Methods Dictionary, observation is one of the oldest methods used by researchers and is frequently combined with other methods such as interviewing and document analysis, which I initially intended to do in the present research project.

In qualitative observational research the role of the researcher is recognized as being subjective. This kind of research bears in mind that events are influenced by the reactions of participant and researcher and this variability is to be considered and addressed and understood by the researcher's reflexivity.

The aim of my semi-structured open-ended questions was to try to examine and evaluate how easy or difficult it was for the therapist to experience reverie. I had devoted some time to writing the interview questions, and they were ready to be applied to the context of the research. Therefore, when I decided to analyze my own sessions, I thought that I would simply use the same interview questions, applying them instead to my own experience, i.e. answering them myself based on what occurred in the therapy sessions. Further along in the process I realized that interviewing myself was not an appropriate way of proceeding with the research.

It also soon became clear to me that content analysis was not in fact appropriate for my particular research goals: “content analysis is a technique used to extract desired information from a body of material (usually verbal) by systematically and objectively identifying specified characteristics of the material” (Reis and Judd, 2000, p. 314). A purely systematic and exclusively objective method did not seem to be suited to the study of the subjective contents so fundamentally a part of reverie. Moreover: “content analysis is

derived from mainstream social science and is used primarily in quantitative research whereas narrative-analytic systems are derived as much from literary and philosophical analysis as from social science and are used predominantly in qualitative research” (Reis and Judd, 2000, p. 327).

On the other hand, a different technique, “Narrative analysis”, had been described by another writer as permitting “a holistic approach to discourse that preserves context and particularity” (Reis and Judd, 2000, p. 327).

In particular, I became interested in a Narrative Analysis method called Therapeutic Narrative Analysis. This was described by Aldridge and Aldridge in “Melody in music therapy: A therapeutic narrative analysis” (2008):

When we chain understandings together to make a story or a case history, then we are composing a narrative account. When we begin to try to understand such narrative accounts then we are using a hermeneutic method of therapeutic narrative analysis. Narrative will be the story that brings these episodes together. In this way we can use a variety of textual materials: written reports, spoken stories, visual media, recorded materials and musical material in the telling of the story. The research part is the analysis of those narrative materials that bring forth new therapeutic understandings; hence, Therapeutic Narrative Analysis (Aldridge and Aldridge, 2008, p.64).

This method fit well with my data analysis because it described the therapy process as made up of “episodes” each of which is unique and each has its own importance. The aim of this research method is to connect the different episodes and give them meaning within a text. Hence “Therapeutic Narrative Analysis” emphasizes context and particulars perceived as a whole and with links to literature and philosophy. This framework seemed particularly suited to my research goals. Therefore, I discarded my semi-structured interview and content analysis, and decided to use Therapeutic Narrative Analysis instead.

### 3.3.1 Two different roles: Music therapist and researcher

In the pilot, which took place in the autumn of 2015, my role was now both that of a researcher and of a music therapist. In reference to playing different roles within the same setting, De Backer had written:

There is an essential importance and relevance of differing therapeutic phenomena such as transference, countertransference, projective identification and reverie, which can be only understandable when these phenomena are experienced. I could only observe, describe and understand them as a researcher after I could experience and feel them as a therapist (De Backer, 2004, p. 3).

I felt that combining my role as music therapist who would experience transference, countertransference, projective identification and reverie, while also acting as researcher would make the research experience a much deeper one.

I had read in De Backer a description of the difficulties of my chosen technique:

It was not always easy to look at clinical material from a research perspective and I often caught myself looking at the material, and expounding my interpretations more as a clinical music therapist. The entire research process was a quest for balance between my familiar clinical thinking, employing a therapeutic conceptualization or 'frame of thought' and a more resistance loaded attitude as 'researcher' (De Backer, 2004, p. 2).

This mostly describes my experience. I realized that I would have to balance my two roles very carefully.

I initially thought it was important not to let my role of music therapist, influence to too great a degree the role of researcher; I subsequently decided that being a music therapist could in fact be help my research. I had worried for example that my research might be "too qualitative". However, what I've come to realize thanks to reading "Melody in music therapy: A therapeutic narrative analysis" by Aldridge and Aldridge (2008) is that just because

experiences are subjective, this doesn't mean they are not valid. In fact, as I discovered in reading the aforementioned text:

In order to understand [...] human experiences, phenomenology uses a method that is discovery-oriented (identifying how phenomena are given in experience) and offers a way of explicating the essential qualities, structures and forms emerging from the experienced phenomena. The starting point is not a specific theoretic perspective but the lived experience (Aldridge and Aldridge, 2008, p. 57).

Music therapy then in itself is very qualitative, in the sense that experiences occurring and felt within the therapy setting are unique and subjective, and it is difficult to discuss and describe processes such as transference, countertransference and/or, specifically, reverie, in a merely objective and pragmatic way. Therefore, experiencing these aspects of therapy in the first person could help further my knowledge and study as a researcher of the music therapy process.

I also decided to implement Aldridge and Aldridge's (2008) Therapeutic Narrative Analysis technique, which they present as a method that is divided into 5 different phases, which I summarize briefly below:

#### *Phase 1*

Collect all the information and data from which to draw a case study. These are the elements from which a narrative will develop. "It is the story you wish to tell" (Aldridge and Aldridge, 2008, p. 64). In the case study that follows examined in this thesis, the story is about Kate, a 29-year-old client, and her exploration of the concept of transition, using symbolizing through music and the analysis of her dreams to help her progress towards a new life and a new sense of identity.

### *Phase 2*

This phase defines an ecology of ideas and settings. It consists in two parts: first, and finding and reviewing a framework of thoughts within the existing literature.

Second, a description of the setting in which the case study took place. Kate's story is explored using the framework of reverie, a concept which has long been applied in traditional therapy settings as was briefly referred to in my earlier introduction to theory but is only now beginning to be applied in the context of music therapy.

### *Phase 3*

Find episodes that are fundamental for the analysis, and that the case study will be composed of. Identify categories (i.e. *themes*) for analysis. Fundamental episodes occurred throughout the 18 sessions of therapy, in particular during the working phase of the process. (Sessions 5 to 14).

### *Phase 4*

The episodes are then submitted to analysis based upon the framework of the themes. The themes I found here are the transitions from old to new life, perceptions of self and interpersonal relations, optimism/positive outlooks (including the positive-negative aspects coexisting in life).

### *Phase 5*

Form a complete narrative of the information which emerged from the analysis of the different episodes.

## **4. CASE STUDY**

### **4.1 An introduction to reverie in the clinical setting**

I started this research process hoping to unveil more about the reverie experience within the clinical setting. Reverie itself is so wavering, delicate, and ephemeral that, though we can be certain that it exists, it is complex to describe the processes and feelings it includes - what the subjective experience actually is. It is difficult to “frame” moments of reverie in a practical way and specifically within the therapeutic context; yet it is precisely in the context of therapy, and its setbacks and achievements, that reverie must be defined.

Reverie is not a single, momentary occurrence which “exists” within therapy. It is rather a continuous part of therapy. Ferro says:

In more general terms, there is, I believe, a constant baseline activity of reverie, which is the way the analyst constantly receives, metabolizes, and transforms whatever reaches him or her from the patient in the form of verbal, para-verbal, or nonverbal stimuli. The same activity of reverie is at work in the patient in response to every interpretive or non-interpretive stimulus from the analyst. The purpose of analysis is first and foremost to develop this capacity to weave images (which remain not directly know- able) (Ferro, 2006, p. 1051).

This ability to weave images, to have a narrative unfolding of the client’s emotional content is at the very heart of reverie. Reverie facilitates thinking about and processing what is happening in therapy.

Initially I had worried that I might somehow try to extort and extrapolate reverie from the sessions, skewing the data to fulfill my need to find reverie. I had read Kenneth Eisold’s article on the practice of Psychotherapy, “The Rediscovery of the Unknown” where he spoke of “a kind of “irreducible objectivity,” a tendency to distort clinical data by fitting it into the theories that make it possible to see what we see” (Eisold, 2000, p. 58).

But I came to understand that episodes of reverie are not isolated events within therapy, but rather an ongoing part of therapeutic momentum, that facilitate the therapeutic relation and process in general, and indeed, that the therapeutic stance of the therapist should also ideally be a reverie-like stance, whatever the specifics of the therapeutic case and setting. Therefore, I did not have to worry about extorting reverie from sessions or imposing theories on the flow-like nature of the sessions so as to find it; for reverie is inevitably present in all therapist-client interaction, at times more clearly, and at times less evidently so - more in the background, but nonetheless always present.

## **4.2 The sessions, structure and activities**

This study took place in the context of an individual music therapy process, composed of eighteen sessions, occurring twice a week and lasting one hour each. The therapy was the second pilot within the music therapy research group described in the methods section. As noted above, the goal of both research and pilots being done in my department, is to determine whether a breathing intervention lasting ten minutes at the beginning of every other session can have effects on the contents of the therapy process and to describe them if found. While this was one important aspect of my case study of Kate, the other goal of my study was to illuminate in a practical way the actual effects of reverie in a particular therapy. Thus, I have analyzed in detail in the following pages the highlights of only those sessions where significant breakthroughs happened. They have been discussed as they fit into my narrative, rather than in their actual order.

The actual music therapy session consisted of 45 minutes and was composed of several activities. The first sessions were the assessment period, where the therapist and client got to know each other and establish a therapeutic alliance. The following sessions made up the central part of the process, the “working phase”. The last four sessions constituted the closing of the process.

The activities in the music therapy sessions were varied. At the beginning of the therapy I used such activities such as drawing or listening to songs brought to therapy by the client, techniques which I had used previously in other music therapy contexts.

However, I later learned that Professor Jaakko Erkkilä, lead researcher and Professor of the research group the process was a pilot of, and other researchers had developed a specific methodology, which has at its core free musical improvisation. One of the aims of the pilot was to further develop this method. Since I had not entirely understood this at the beginning, I used activities (drawing and listening to songs chosen by the client) that were not a part of this methodology, and which did not have free improvisation at their center. After the first few sessions Professor Erkkilä and I cleared up this misunderstanding, and I stopped using the songs brought by the client and the drawing. This is not to say that these activities were not fruitful and significant in helping the client express herself and get further in touch with her emotions. However, given that they were not part of the conceptual framework of the pilot, it is important that we were able to communicate and make clear my specific role in the project.

#### **4.2.1 The instruments**

It was established that the IIMT (Improvisational, Integrative Music Therapy) therapeutic model called for only two instruments to be used during the improvisations: the malletkat, a midi metallophone, and the djembe, also midi in this case. The instruments needed to be midi for research purposes so that the improvisations could first of all be saved on a computer, and then analyzed and processed. The model called for the use of these two instruments alone because they do not require a high level of previous musical (instrumental) experience; in fact, the metallophone and djembe are among the easier instruments to approach for clients with little or no musical background. Another requirement for research purposes, so that the data could be consistent, and consistently analyzed, was that we play at least one improvisation on the malletkat per session, lasting a minimum of two minutes. During most

sessions it turned out, the improvisations were done exclusively on the malletkat for the whole session, with the exception of three sessions during which the djembe was also used.

### **4.3 The balance between verbal and musical communication**

#### **4.3.1 Our opening activity: The initial talk**

Nearly all sessions began with an initial talk, the duration of which varied vastly from one session to the other, as follows: In the first four sessions, this initial talk did not last very long, that is to say, about 5 minutes. The talk at the beginning of session number 5 lasted 15 minutes. During session number 6, there was no initial talk; my supervisor had suggested that it might be beneficial to try starting the session with directly playing music instead of talking and we experimented with this in this session. In the following session (number 7), the talk again lasted 5 minutes, as it had in the initial four. Towards the beginning of the working phase, in the central part of the therapy process (session number 8), there was an important break-through: the initial talking phase lasted all of 30 minutes. This brought forth the realization that the client very much needed someone to talk to, and someone to listen to her. This was also when she began to narrate the unfolding of her dreams, which needless to say was extremely relevant for the therapeutic work of the process.

After this breakthrough in session 8, the initial talks began to be longer, averaging 15 minutes per session, with peaks of 30-35 minutes in sessions 14 and 15.

### **4.3.2 The improvisations**

Following the initial talk there were usually at least two improvisations. The improvisations almost always had a theme, derived from the content of what the client brought up during the initial talk. At the beginning of the process, the theme was also sometimes inspired by a song brought in by the client which we had listened to at the start of the session, after the initial talk.

After the playing ended, we usually discussed how it felt to play and if there were any images, feelings or thoughts that emerged whilst playing. As a music therapist in training, I learned through this process (among many other things) that this phase of talking about the music played during the improvisations and what it brought up is very important and therapeutically relevant because it is one of those crucial moments when a window opens between the client's and the therapist's minds. Being that it is such a delicate and important moment, it is beneficial for the therapy (if possible) to stay in this moment for more than just a few minutes and continue talking to each other, instead of starting to play almost immediately (as I tended to do during this particular process).

## **4.4 The client**

I will refer to my client as Kate, to protect her privacy. She is a 29 year old student from China.

Kate applied for music therapy primarily because she was having to deal with stress related issues. During our first sessions, I learned that most of her stress concerned her academic life and achievements. It seemed in fact, that her family had always put her under a lot of pressure to succeed academically (and continued to do so), though she seemed to have developed some positive mechanisms for dealing with the pressure. She was relatively calm about deadlines

and seemed able to keep her academic challenges in perspective, locating them within a wide range of other components that made up her life. Another important aspect of her life which was in some way problematic for her was her previous relationship. Towards the end of session 4, the first session where Kate really opened up about her past, she began to tell me about the end of her last relationship, which she had struggled to come to terms with for some time; she also said that she finally had accepted it and was feeling ready to move on. It was in this moment that the theme of being ready for and wanting a “new life” emerged. In fact, in the following sessions we dealt with this theme, trying to explore musically what a new life, a new beginning, might feel like.

## **5. THERAPEUTIC NARRATIVE ANALYSIS. THEMES AND EPISODES**

In this section of my thesis I will refer to various therapy sessions as they relate to themes I am discussing, rather than in numerical order.

### **5.1 Transitioning, towards a new beginning**

A recurring theme, “transitioning”, which emerged in the course of the therapy expressed the desire for a new life very clearly. Kate approached and dealt with this concept both musically and verbally in most of our sessions together. In particular, in session 7 Kate made a leap forward in terms of the transitioning theme, discovering a new way of playing and being in therapy, and hence in life.

In session 7 we play a malletkat improvisation that lasts 9 minutes, which is much longer than any of the previous improvisations we played together. Usually the improvisations lasted on average approximately about 3 to 4 minutes.

I found this improvisation to be really beautiful, and sensed in it the beginning of a true and deep connection between us. There were several moments of intense synchronization. For example, we both played the last note simultaneously and then looked up at each other stop and smiled.

This improvisation was the third activity in this session. At the very beginning of the session we talked for four minutes. This was immediately followed by two improvisations on the drums. Then came the malletkat improvisation. I think that in part the malletkat improvisation was so meaningful because of two factors: one, the initial talk only lasted four minutes. Two, the session mostly comprised a series of musical interactions, first two on the drums, then the one on the malletkat. We did various exercises on the drums which had specific purposes. First, we played slowly, and then fast and then slowly again during the same improvisation, which helped our synchronization and ability to listen to each other. As the client herself said,

“somehow... communicating”. Following this we improvised on drums by taking turns, so as to focus, here too, on enhancing our ability to “tune-in” with each other and to listen to each other, facilitating musical and emotional communication and openness. The two drum improvisations helped in building a therapeutic alliance. Significantly, in the discussion following the two drum improvisations another important therapeutic event occurred. Kate’s ability to symbolize emerged. While reflecting about the music during her verbalization she said: “sometimes it was like rain, like the sound of the raindrops on the window”. Symbolizing, as mentioned in the theoretical section of this thesis, is a way to re-appropriate contents which emerge during reverie; it is a process which allows us to access more easily and give name to unconscious elements which we were previously less aware of. Kate tended to use imagery from nature to describe her emotional states. Nature in fact emerged as a theme throughout the therapy. The word “window” is also very meaningful here. The window theme occurs again in another breakthrough moment in session 13. This theme represents a seeing through, a looking beyond, and acknowledging, but at the same time shielding, (i.e. protecting) oneself from what is seen. Things seen through a window are there and are not there at the same time. This also allows us to be in two places at the same time, for example inside and outside, which is relevant to the fundamental and recurring theme of transitioning, one of the most important themes in this therapy. The length of the malletkat improvisation, which I see as a step forward in harmony and trust between us, was clearly facilitated by the previous improvisations on the drums. I had suggested that the theme for this malletkat improvisation would be transitioning, and in fact after playing, Kate reflected on how one can define transitioning, and its different forms and manifestations. She said that transitions can be brief or long; they can even happen in the course of one day, and be as fleeting as the changing expression of emotions on a face, “like the appearance of color on someone’s face”, clearly visible. But Kate also wanted to embrace long-term transitions, “calm down, *slow down* a little bit and not push everything in a hurry”. It seemed that the length of the improvisation itself (with its slower and more modulated transitions) was a breakthrough for Kate, a walking towards lengthening experiences and rushing herself less, being less in a hurry. At the beginning of the therapy process Kate tended to jump around a lot in the music, playing in brief bursts and immediately changing from one rhythm or style of playing to another.

I had first noticed a beginning of this slowing down in session 5, when I asked Kate to play about “a new start”. This session occurred at what I considered a turning point in the therapy process, the beginning of the working phase. Session 4 was the last session of the assessment phase. Interestingly, session 5 was permeated with a sense of reverie, full of symbolization and rich in musical metaphors. In this session, Kate said she felt she had “very different personalities, like the three parts of the keyboard”. For example, to her, the lower part of the keyboard was “calm and logical”. Could this suggest, that the idea of time in reverie, and dreams is similar to the idea of time in art and music?

Considering how important dreams were for Kate and what a central role they played in her life, it is possible that her dreams allowed her to be more open and receptive to reverie and towards finding her own improvisational style. It is certain that Kate’s gradual progress towards her objective of “calming down, doing things less in a rush” *musically*, made it possible for her to be more open to experiencing reverie within therapy.

However it was in session 7, that Kate truly musically slowed down, and that the pivotal episode in the “transitioning” theme occurred.

## **5.2 Identity and interpersonal relations**

### **5.2.1 The workplace**

The transitioning and the identity themes were closely linked. The occurrence of her experiencing transitioning in her life allowed her to further develop, explore and define her sense of identity and of a new identity. In fact, the music therapy process was profoundly connected with a period of transitioning in her life. “Especially for this period music therapy is kind of exactly in (a time) of transition in my life, kind of after those two years hopefully...

my doom days can finally be over... anyway the direction can be quite positive for me” (session 12).

Session 5, at the beginning of the working phase, was also important for the beginning of the emerging of the identity theme. As is always the case in therapy, session 5 built on the sessions of the assessment phase, and in this case session 4 in particular.

Session 4 was the first session where Kate really opened up and told me about her last relationship which had ended two years previously. She also told me she had just started getting over this relationship and was beginning to think about approaching a new start. At the beginning of the session Kate talked about being annoyed at a colleague because her colleague had refused to collaborate with her on a research project. I then suggested she *play her colleague* in an improvisation, so that she could try to identify with her colleague and see things from her point of view. Kate’s immediate reaction was that the colleague’s experience was “heavy, some burden, a not-so comfortable experience” “maybe she feels very tired because we talked online on Friday evening so somehow I can understand her”. When Kate came to the next session (5) her first verbal reflection was about her colleague, about how “every cloud has a silver lining” and how everyone has problems so one shouldn’t judge them. The symbolization here once again expressed itself through natural imagery. She meant that she should not judge her colleague but should try and understand her. In both sessions 3 and 4 Kate had been critical of her colleague and resented her refusal to collaborate. Two therapy sessions later it had become clear to both of us that the colleague, as Kate had intuited, was very busy and tired and overburdened by her work. This seemed to me to be the first true therapeutic breakthrough in this therapy process. A musical intervention had born visible fruit and had allowed Kate to change perspective on an important issue in her life.

I felt the shift from judgment to understanding was important both from the point of view of transitioning and of identity, in that in dealing with an important transition Kate was also able to establish her identity more clearly in relation to others. By establishing a relation of

understanding with someone, she was able to define her identity of self as someone who is understanding both of others and of self.

### **5.2.2 The family**

Session 5 was pivotal for Kate's re-appropriation of her relationship with her family. It was also an important session, as the therapist for the first time in this therapy I had a first intuition of reverie. In my notes from session 5, I found an image which in retrospect has become important for my subsequent analysis in this thesis and my understanding of the whole therapy process. In my notes I had written in reference to the beginning of the session, before the actual music therapy session began, during the fifteen minutes of the paced breathing or control activity, that Kate's "crossed arms reminded me of a child who is mad with her mother because she doesn't care enough about her". Crucial improvisations for Kate during the therapy dealt with both her mother and her father and around this session the therapy began to hone in on her internalization of both of her parental figures and in particular the problematic and at times traumatic relationship with her father. Therapy later revealed that her anger was directed at her father rather than at her mother. My intuition nonetheless remained a helpful one and was illuminating to me as a young therapist.

When I first re-read the above sentence in my notes, I had thought that this might reflect a form of transference, of my carrying over my personal life and world into that of my client, and should immediately be disregarded. However, my readings on reverie taught me to give weight to all the associations of the therapist, as well as those of the client coming from and created by the shared interpersonal space. Almost immediately, the following clear association, this time to the client's emotional experience, came to mind: I remembered that in session 10 (5 sessions later), Kate opened up and recounted the traumatic experiences from her childhood, experiences involving her father's violence at home. During session 10 she described her father as having a very ambivalent character, at times very cheerful and at others very disagreeable. She said he was unpredictable and that although outside the home with neighbors or strangers he was open and agreeable, whilst at home he got angry very easily. She supposed that there might be a kind of person that behaves well with people

outside the family environment, who behave harshly in their own home. I asked her how this made her feel and she said “quite angry”. This is an example of how the narrative method helped me to recognize and frame the constructive therapeutic thinking that can emerge from traces of reverie.

### **5.3 Symbolization and dreams**

Sessions 5, which has already revealed itself in this thesis to be pivotal for my work, and 10 are both important for their content of symbolization and dreams which helped to clarify Kate’s new and old relations to her family.

Session 10 is important because Kate speaks in great detail about her dreams, which lead to a greater openness about her relationship with her parents. Kate discusses how she has dealt with interiorizing their very different, almost opposite, personalities: “my parents have almost opposite quite extreme, different personalities; my mom can be quite soft, very good temper, very nice person thoughtful and can think of others from their side. but my dad has a very bad temper and always lost his temper even without any reason sometimes during my childhood I didn’t know why he got angry. broke things in the home maybe reason for my nightmares. one of the important reasons why I wanted to go abroad. get rid of the bad atmosphere in my family. so I kind of have both the extreme personalities in myself sometimes it’s hard to control the personalities so I have the impression that I have some kind of split of my personality in two extremes things. that I can’t find the overlap section of them.”

Sessions 5 and 10 contain the themes of overlap, and the musical metaphor of different parts of the keyboard corresponding to different personalities. Session 5 presents an image of harmony and integration which acts as a point of departure for the working stage.

In session 5, Kate plays, upon my suggestion, a new beginning and says subsequently of the improvisation: (I have) “very different personalities, like the three parts of the keyboard, lower, calm and logic, then if I meet someone very extroverted I will also become extroverted [...] they overlap and are integrated”.

Session 10 further clarifies and deepens the metaphor and introduces the new metaphor of being lost. Symbolically, being lost (both geographically and emotionally) for Kate is a starting point which allows her to discover new things and to see different sides of herself. In her dreams, she dreams that she is lost in cities, and at the same time in therapy she is *at a loss* as to how to orient herself between the two fixed points (or poles) of her parents very different, incompatible personalities. “I kind of have both the extreme personalities in myself sometimes it’s hard to control the personalities so I have the impression that I have some kind of split of my personality in two extremes things that I can’t find the overlap section of”. Kate cannot orient herself internally and therefore cannot orient herself externally. “between my two personalities I kind of have good logic for my studies I can calm down but sometimes I will be maybe too sensitive or emotional so that I cannot control but I will think from a much clearer point of view it will be reflected in my journey that I will get lost in some cities. I don’t know how to manage the personalities well”. The personalities she feels lost between here are the very different personalities of her parents.

On further reflection about the content which emerged from her dreams and the other things she brought up during this session, I realize that there seems to be a link, a connection, a common theme emerging from the different elements. On the one hand, when talking about her dream she says that she often dreams about being lost in cities, on the other when speaking about her parents she says she felt it was hard to balance between her parents’ personalities; so, in a sense, she was not only lost in her dreams, but she was also lost or, *at a loss*, about what to do about the emotional models she had been shown by her parents. orient herself between/in these two different directions.

In both sessions, 5 and 10, Kate talks about different parts of her personality. In session 5,

where Kate was talking and playing about herself and her own autonomous identity and the perspective of living new experiences, she was able to express integration. In session 10, where we were instead discussing, verbally and musically, her past and her identity in terms of her parental figures, she was not able to feel the “overlap”. But at the same time, in session 10, in the musical metaphor, after playing her mother, Kate says: “around this part (upper keys) is like sunshine, I feel quite warm and happy. my mom often shows up in my dreams as a positive figure.” This is a beautiful image and this kind of personality is very similar to Kate’s own, which shone through every session. Perhaps this hints at a next step, after therapy, when Kate will be able to accept both her inner conflicts and the shortcomings of those around her more easily.

#### **5.4 “Playing” the father: towards recognizing reverie and the therapeutic process**

Session 11 was very important for building trust between us. We musically deepened the discussion that addresses the theme of her relationship with her father i.e. we played her relationship with her father on different instruments and with a series of activities, discussed below in more detail, which addressed different aspects of the relationship. Before playing about her father, Kate talks again about the way her father would sometimes be violent towards her. She tells me about an incident when once as a child she sighed loudly and her father said: “why did you breathe like that?”.

In particular, this session was dedicated to improvising musically about her father in different ways and from many different points of view. The therapeutic goal of these different improvisations was to have Kate re-live her father’s aggressiveness, giving her at the same time the opportunity to be aggressive towards her father herself, to express the pent-up anger towards him which I felt she had been keeping inside for many years. In the first improvisation I suggested that Kate play herself and that I play her father both of

us on the drums; I asked her to give me directions on how I should play him. Kate said: “you’re in a bad temper or you easily lose your temper or criticize everything”. I played in a disconnected manner, trying to be unpredictable and to interrupt her playing. Then in the second improvisation I suggested we play together again on the drums, this time experimenting with volume, playing softer and then louder together. My idea here was to let Kate experience and experiment with being loud, since as an introvert she tended to be on the quiet side. She also usually had not seemed prone to express anger directly herself. From what she had told me about her father’s personality, he was loud and unpredictable and often raised his voice. I wanted Kate to be able to re-live and re-experience quick shifts in both intensity and volume, expressing herself more loudly than usual and with less inhibition. In the third drum improvisation, I asked her to play again softer and louder, but this time, when I played loud, I asked her to play louder than me, covering me with her drumming. This activity was done to reach the same objective as before, that is to allow Kate to re-appropriate her feelings of anger and disappointment towards her father.

We then played a last improvisation on the malletkat, where I suggested playing the more positive aspects of her father’s personality, so as to also allow her to appreciate the fact that he too, as every other human being, had a valuable side to him, which she had in fact at times remembered and discussed.

I felt this session was also important for the building of trust because during the ten minutes of the control intervention before the actual session, which consisted in sitting in a vibro acoustic chair, Kate actually fell asleep. When I asked her in session 12 about what she thought of the therapy so far, she brought up with contentedness the fact that she had fallen asleep in the previous session. She said she had even shared that moment afterwards with her parents and her friends. “I was quite tired especially sitting on that chair is like Freud with people the patients lying down in that kind of chair like Freud half asleep and they can share something the same thing sitting in the chair”. I also responded positively to this episode, answering her fondly and saying that for me it was as if there had been a child in the room. I also told Kate I was happy this moment had occurred because it meant that we had established an environment of trust within the therapy setting. Her falling asleep brought out a very caring

instinct in me towards her. I believe this was very important since a fundamental aspect of the therapeutic relation is the therapist's sympathy towards the client.

## **6. TOWARDS A CONCLUSION; KATE'S STORY REVISITED, REVERIE IN AND OUT OF THE THERAPEUTIC SETTING**

Session 12, which was towards the end of the working phase of the therapy, was another important and pivotal session; the session started with paced breathing and it contained the shared acknowledgment of the presence of reverie in our therapeutic process and the possibility of reverie moving beyond the therapy process into Kate's everyday life.

Kate also redefined her original story, facing once again the original issue which prompted her to come to therapy in the first place, i.e. pressure to succeed academically and beginning to find a solution to it. Interestingly enough, Kate addressed this issue through her dreams, discussing the recurring nightmare she had about not having prepared for an exam, and the anxiety that produced in her. By talking and playing about this dream content Kate was able to shift into a more relaxed perspective.

Session 12 contained three improvisations; I will focus on the first one as it was extremely important for the concept of reverie. The first improvisation had a high emotional resonance for me. Her playing had beauty and was telling a story. Kate plays with a sense of purpose, which was a new development in the therapy process. Listening to it even now I find myself entering a state of reverie. I'm lost in the music, my imagination is enlivened, and it is like being in a daydream. The music created in the interpersonal space of the session allows reverie to occur again, retrospectively, even when listening to it in the present.

The conversation that follows is also meaningful and therapeutically relevant. The client's first reaction was to say: "quite a mess". What Kate called quite a mess seemed to me like a purposeful chaos which had been freeing for her and was beautiful, permeated with reverie. I hypothesized and said to Kate that on the contrary it was possible that she had been able to feel more free during the improvisation because the theme that was selected was "stress" and "not having prepared for an exam". "Maybe when playing about stress you felt more free because you didn't have to worry about the right way to play". "It seemed like you were really expressing yourself". After I expressed these thoughts, Kate immediately brought up

the *flow state* (a state analogous to reverie). “My professor said lots of things about how to control your mind, he told something about flow state, concentrating on the work so much that we cannot feel the time which flies quite fast. how to achieve that kind of state is quite difficult, especially at the start”.

Since what Kate and her professor referred to as the flow state is very similar to what many have identified as reverie, I asked her if she had ever reached this state during the music therapy sessions and she answered “sometimes, I shared an interesting topic with you, I didn’t notice it was 5 o’clock already”.

We then discussed how it is possible to employ the flow state creatively, saying that famous writers may use it for writing. I mention stream of consciousness – a technique used in modernist literature - and that it would be great to be able to use it for studying. Kate says that it has been impossible for her to reach this state when studying, because she is always looking at the clock when studying.

Throughout the session Kate talks about her wish to be able to control her life and after playing what I thought was a purposeful improvisation, she talks about her playing being disorganized and a mess. I reflect that it seemed like she was really expressing herself, and that when one hasn’t prepared for an exam one has to improvise, which is what we were doing musically here, so in a way it was easier for her to improvise when playing about not having prepared for an exam. My message to her was that it is best not to worry about controlling things too much, and that one can achieve order even through chaos. Improvising is an important part of life and I think it was of help for Kate to experience it musically, in that it was constructive and liberating for her. It could be a valid alternative to controlling, a theme which ran through the sessions. In fact, musical improvisation was at the core of this process and perhaps experiencing it helped and will continue to help Kate to find serenity and new solutions to problems both in her current and in her past life. The session ended on a beautiful note of hope: “life is so fragile and people cannot easily

protect themselves from risks or if something happens [...] so I said why not just take care of myself and treasure life instead of always thinking from the negative side so sometimes dealing with quite negative things I still have hope, I say still all the bad things and all the bad situations will still be better than death, the end of life at least”.

By articulating together and discussing the flow state, which is reverie, we have helped this, perhaps, to become a model for Kate as a way of solving problems and dealing with issues related to her studies but also to other parts of her life.

We talked about the flow state explicitly and by framing it with language, we acknowledged it.

It is important to note here that the initial reason Kate came to therapy, stress due to academic pressure, re-emerged in this session, allowing her finally to confront it and deal with it. That she mentioned the flow-state as a model of creativity to follow so as to be more enabled to study well, was an important breakthrough. I think that experiencing reverie (the flow state) in therapy allowed her to re-evaluate this kind of state and will help her to try and experience it in her every day life.

## **7. CONCLUSION AND PERSONAL INSIGHTS**

This case study about Kate, part of the larger study referenced earlier, and my written narrative about it resulted in insights which were useful in two ways. First, the study illustrated the therapeutic effects of reverie on patient and therapist. In the course of the study, Kate was helped to develop insights which led to important improvements in her feelings and attitude about herself. It also contributed to my ongoing process of becoming a music therapist by helping me to a better understanding of reverie. This understanding was deepened and enriched by my reading of basic theory underpinning the concept of reverie. I have attempted in this thesis to provide a brief snapshot of some of the various theoretical points of view of several important writers in the field. The second practical outcome of the case study was helping to confirm the measurable physical effects of paced breathing interventions and their usefulness in furthering the development of reverie in the subject of the study.

It is my hope that other therapist's may benefit from all of the insights theoretical and practical which were of such help to me in conducting the case study, in beginning to explore the writing in this field, and in thinking about and writing this thesis.

## References

- Aldridge, D., & Aldridge, G. (2008). *Melody in music therapy: A therapeutic narrative analysis*. Jessica Kingsley Publishers.
- Bruscia, K. (1989). *Defining music therapy*. University Park, IL: Barcelona Publishers.
- Bruscia, K. E. (2013). *Defining Music Therapy* (3). University Park, US: Barcelona.
- Bion, W. R. (1962). *Learning from Experience*. London: Heinemann; New York: Basic Books.
- Bion, W. R. (1963). *Elements of Psycho-Analysis*. London: Heinemann.
- Bion W. R. (1965). Transformations: Change from learning to growth. London: Heinemann.
- Bion W. R. (1978). São Paulo clinical seminars. In: Clinical seminars and four papers, p. 131-222. Abingdon: Fleetwood Press, 1987.
- Caldwell, L. (Ed.). (2007). Winnicott and the Psychoanalytic Tradition: Interpretation and Other Psychoanalytic Issues. London, GBR: Karnac Books.
- De Backer, J. (2004). Music and Psychosis: The transition from sensorial play to musical form by psychotic patients in a music therapeutic process. Music and Psychosis: The Transition from Sensorial Play to Musical Form by Psychotic Patients in a Music Therapeutic Process.
- DeCasper, A., & Spence, M. (1986). Prenatal maternal speech influences newborns' perception of speech sounds. *Infant Behavior and Development*.
- Eisold, K. (2000). The Rediscovery of the Unknown TL - 36. *Contemporary Psychoanalysis*, 36 VN - r (1), 57-75.
- Erkkilä, J., Ala-Ruona, E., Punkanen, M., & Fachner, J. (2012). Creativity in improvisational, psychodynamic music therapy. *Musical Imaginations*, 414-428.
- Ferro, A. (2006). Trauma, reverie, and the field. *The Psychoanalytic Quarterly*, 1045-1056.
- Forinash, M. (1995) 'Phenomenological research.' In B. L. Wheeler (ed.) *Music Therapy Research: Quantitative and Qualitative Perspectives* (pp.367- 387). Phoenixville: Barcelona Publishers.
- Given, L. (2008). *The Sage Encyclopedia of Qualitative Research Methods*.
- Hooper, J. (2001). An introduction to vibroacoustic therapy and an examination of its place in music therapy practice. *British Journal of Music Therapy*, 15(2), 69-77.
- Ogden, T. H. (1992). *Matrix of the Mind: Object Relations and the Psychoanalytic Dialogue*. London, GBR: Karnac Books.
- Ogden, T. H. (1994). The Analytic Third: Working with Intersubjective Clinical Facts. *International Journal of Psychoanalysis*, 75, 3-19.
- Ogden, T. H. (1999). *Reverie and Interpretation: Sensing Something Human*. London, GB: Karnac Books.
- Ogden, T. H. (2001). *Conversations at the Frontier of Dreaming*. Jason Aronson.

- Ogden, T. H. (2004). On holding and containing, being and dreaming. *The International Journal of Psychoanalysis*, 85(6), 1349-1364.
- Reis, H. T., & Judd, C. M. (2000). *Handbook of research methods in social and personality psychology*. Cambridge University Press.
- Reverie [Def. 1]. (2010). Stevenson, A. (Ed.), *Oxford Dictionary of English*.: Oxford University Press. (3rd Ed.).
- Rollins, H. E. (ed.). (1958). *Letters of John Keats*, Vol. 1, 193-4.
- Våpenstad, E. V. (2014, July). On the psychoanalyst's reverie: From Bion to Bach. In *International Forum of Psychoanalysis* (Vol. 23, No. 3, pp. 161-170). Routledge.