Master's Thesis

An Early Interaction Music Therapy Model

by

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Tiivistelmä – Abstract

This case study presents a threefold Early Interaction Music Therapy Model which is created in the child protection context. It contains mother-infant music therapy and mother's own music therapy processes. The first two parts occur in mother-infant music therapy: inviting the infant to contact by music and supporting the mother in mirroring her infant musically. The last part occurs in the mother's own music therapy where she may explore her feelings and issues which inhibit her from adequate interaction with her infant.

This research investigates the mother's own primary family interaction, her present family dynamics, her life crisis and their influence to her interaction with her infant. These issues were also studied in relation with the infant's masturbation symptom and rejection of mother's initiatives.

Interaction was quantitatively pre- and post-tested with Early Interaction Video Assessment Method, Care Index. Also the gaze, face and act contacts were measured in the beginning, in the middle and in the end of the mother-infant dyad's music therapy process. Both music therapy processes were also explored qualitatively based on the therapeutically important issues arisen.

The results highlighted the importance of the mother's own process for exploring the projections in the background of early interaction challenges. They also brought up the possibilities of music therapy in early interaction work – not only in investigating the psychodynamic background of the mother, but also in terms of the essentiality of processing actual crisis to prevent projections which inhibit adequate interaction between the mother and the infant in the present.

Asiasanat – Keywords	Music Therapy, Early Interaction , Projection, Mourning, Infant Masturbation
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1. INTRODUCTION

Early interaction is an increasingly growing area of research. It has been indicated in studies, that early interaction and attachment security have a remarkable influence to the development of an infant's brain and psychic well-being (Hautamäki, 2001; Glaser, 2001; Fonagy, 2001).

Quality of attachment has been reported to be quite continuing across generations, especially in middle-class, stable family environments. Despite that, early conditions are not seen as defining individual potential; natural maturation and changes in environment and relationships may create adaptation to new strategies. (Hautamäki, 2001, 2010.)

Mother-infant treatments and interventions have been reported to have an influence to symptom relief with infants and to the reduction of mother-infant conflicts with mothers becoming less intrusive in their behavior and infants becoming more cooperative (Robert-Tissot et al., 1996; Cohen et al., 1999).

This study is based on the author's clinical work in child welfare during ten years in Helsinki. It has been challenging to find effective ways to support and treat high risk families in foster care. Early interaction work for outpatient families has been grounded on home-based or institutional treatments. The aim of this work has been to strengthen the level of parents' sensitivity to their infant's emotions and initiatives to create a good enough parenthood and thereby to prevent a situation where the infant is taken in custody.

It has turned out to be complicated to increase the sensitivity of parents who lacked the models of good enough interaction and sensitivity in their own childhood. Clinical experience shows that verbalizing the infant's emotions and guiding the early interaction is insufficient to create an adequate level of sensitivity. It seems that it is also necessary to work with the inner interaction

models and traumas of the parents to create more understanding to their emotions and thereby strengthen their sensitivity to the inner life of their infants. Psychodynamic therapy offers one opportunity to work with the parent's inner models. The processes are, however, long and sometimes it is challenging to reach the earliest phases in the life of the client - the phases of non-verbal communication and interaction.

Music therapy clinical work with high risk families has suggested that music may offer an effective way of contacting these pre-verbal areas (Lipponen, 2008). Music may offer a path to emotions and interaction which is grounded on the very early phases of parents' lives. Clinical work has demonstrated that parents may feel safe and emotionally received when supported by musical interaction. It seems that parents commit themselves quite well to the music therapy process. (Lindroth & Romo, 2008.)

Music therapy has been used as a therapeutic medium for different purposes. Despite the diversity of these purposes, connective dimension in music therapy processes is, -in most cases, it's emphasis on the relationship and interaction achieved by music (Wigram, Saperston & West, 1995). Communication in music therapy is based on the balance between following and initiating with musical interaction (Oldfield, 1995). As the interaction between a mother and her infant is composed of similar dynamics, music therapy has proved to be an effective treatment in the field of early interaction.

Although there has been an increasingly growing interest in early interaction in the scientific world and music therapists have written creditably of the interactional nature of music, early interaction has not been studied in the broader context of music therapy. In Finland, music therapist professionals have set up a group which has created an orientation for early interaction music therapy.

In clinical practice, there has been some evidence of connections between the generalized interaction patterns and dynamics of musical improvisation. The first research question in this study was founded on the author's clinical experience and it set out to investigate whether it was possible to influence mother-infant interaction with processing and verbalizing the mother's psychodynamic history through the images arisen from the musical improvisation. This question changed due to the data that resulted from the process, as is natural in case of abductive research. Although this question didn't end up being the emphasis of this study, it would be useful to investigate these connections more closely.

The deprivations and traumas of the parent originating from her primary family may inhibit the parent from diverse interaction, and these inhibitions can also often be recognized in her musical interaction and expression. There may be challenges relating to stepping to different musical polarities, diverse expression and initiating or following in improvisation. These inhibitions may also be seen in the musical interaction, dialogue and mirroring of the infant. Processing the inhibitions of musical expression may lead to the early experiences of the mother and give her the opportunity to release her expression and mirroring capacity in the early interaction dialogue, too. In other words, there may be a possibility to influence with music therapy the earliest phases of a mother's interaction experiences and through that have a medium for influencing and handling the interaction between a mother and her infant at present. (Lipponen, 2008, 2010.)

The expressive musical dialogue between a mother and her infant may be also inhibited by a present crisis in the family. The way of handling a crisis is dependent on the attachment and interaction experiences of the person involved and these experiences obviously influence the process simultaneously with the actual emotions arisen from the crisis.

This music therapy case study explores how this medium of interaction can be used as a treatment in the context of challenges present in the early interaction between a mother and her infant and as a tool for processing the mother's present emotions and primary experiences of her own interaction in childhood. It compares the phenomena in early interaction music therapy improvisation and play between the mother and the infant and the mother's own improvisation and verbal processing of her early and present experiences. It also looks for connections between the mother's improvisation, verbal processing and dyad's interaction patterns.

Because this case study involved a mother who had suffered extreme losses during a short time the actual crisis turned out to be the essential issue processed, - even related to the challenges of early interaction with her daughter. It turned out that this special case study gave an answer to the following question: "Are there connections between a mother's improvisation and her way of interacting with her daughter?" "Is it possible to process interaction challenges through musical improvisation and verbalization of the musical content of the improvisation? This study concludes by answering the following question: "How is it possible to help the mother to process her crisis through music therapy work and consequently, to support her in her interaction with her infant?"

This study begins by looking at the theoretical background of Early Interaction Music Therapy (EIMT) and the mother's own music therapy. After the theoretical part it presents a case study of mother-infant early interaction music therapy and parallel music therapy process of the mother. The

case study includes the reflections of the theoretical and therapeutic issues occurred in each part of the music therapy processes which should be seen as the qualitative results of the study. The last part presents the results of a quantitatively measured pre- and post-assessment of mother-infant interaction. Finally, in the discussion, the new theoretical findings from the research are gathered together to form a new theoretical foundation of Early Interaction Music Therapy Model.

In this study the word "mother" means the most primary caregiver of an infant, so it may in practice be any other permanent adult closest to the infant.

2. REVIEW OF THE LITERATURE

2.1 Dynamic Maturation Model of Attachment and Adaptation

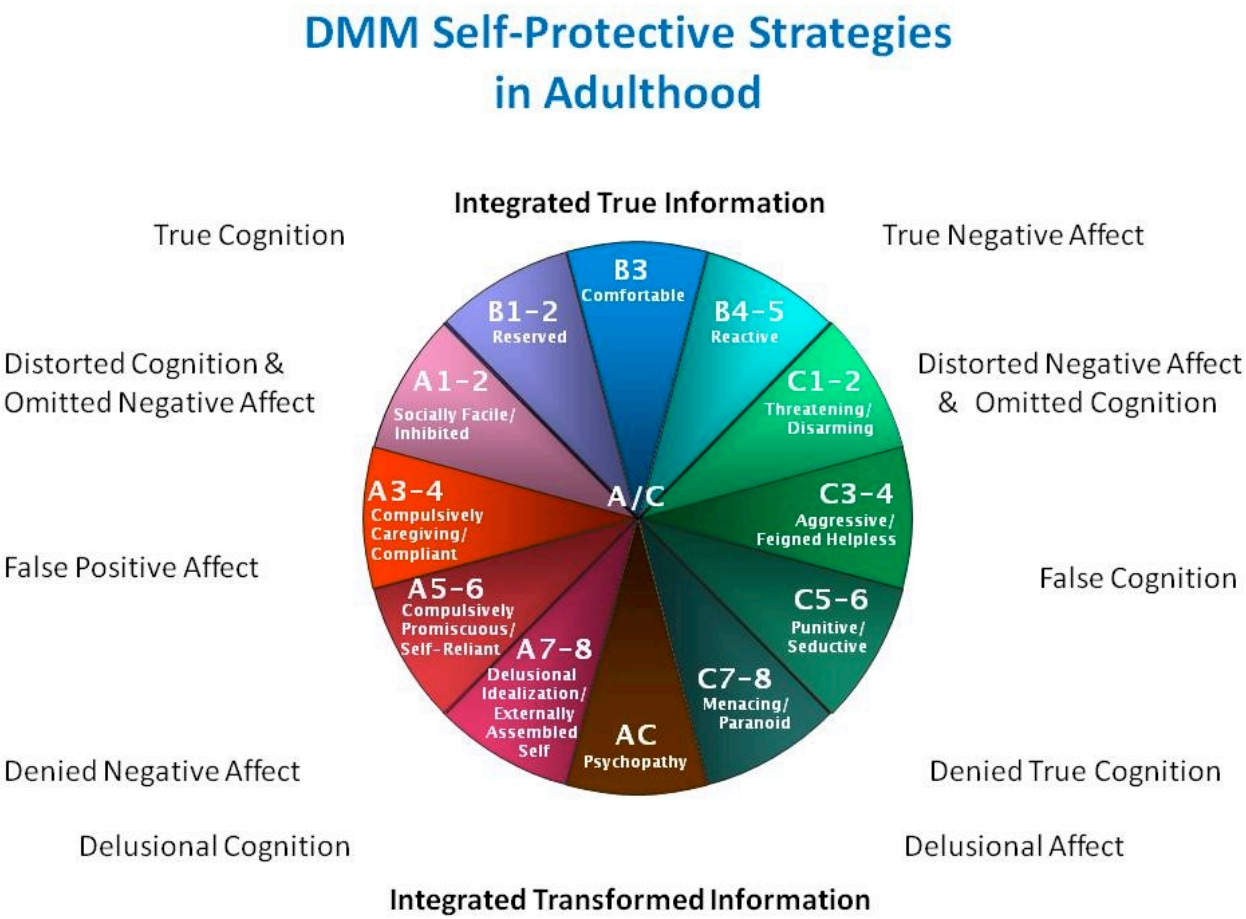
Early interaction assessment tools have evolved increasingly in recent years. Most techniques used are based on microanalysis of videotaped interaction situations. Videotaping gives an opportunity to return repeatedly to details of the situation to assess the interaction (Mäkelä, 2003, p. 368).

Patricia Crittenden (1995, 2001) has developed an assessment tool called the Dynamic Maturation Model of attachment and adaptation (DMM), which is founded on the work of Bowlby and Ainsworth. Farnfield, Hautamäki etc. (2010) have reported the procedures, validity and utility of DMM assessment mediums. DMM approaches attachment and adaptation models by conceptualizing danger as a key factor in the organization of attachment behavior. It is created to investigate the strategies that offer a maximized protection under threatening conditions.

According to Crittenden (2001), DMM attachment classifications may be examined through different attachment classification types. Classification is completed with more attachment types from childhood to adulthood. The main idea of the DMM classification is that:

- Type B pattern of attachment includes persons, who are able to balanced use of both cognition and affect
- Type A pattern of attachment includes persons, who rely on exaggerated cognitive predictability and ignore (inhibit) negative affect
- Type C pattern of attachment includes persons, who rely on exaggerated negative affect and ignore cognitive unpredictability.

(Crittenden 2008, p. 20.)



Studies have provided evidence for attachment stability across generations. The highest correspondence seems to be in the transmission of Type B and Type A when the child is 1 and 3 years old (Hautamäki, Hautamäki, Neuvonen & Maliniemi-Piispanen, 2010).

In early interaction work, parents have different kinds of self-protective strategies, which have been developed as a response to the demands of the emotional situation of a parent in her childhood. On order to create a successful early interaction treatment, it has proved to be necessary to process parents' self-protective strategies. This requires a long enough relationship with the parent with experience of safety and trust. (Lipponen, 2008; Uusitalo et al., 2005.) This study includes the assessment of the early interaction and the DMM patterns of the adult.

2.2 Treatments for Early Interaction

The mother may need *psychodynamic* support for her own feelings to be able to mirror her infant (Kalland & Maliniemi-Piispanen, 1999). An empathetic therapist may offer the parents understanding, empathy, consistency and mirroring which helps them to recognize themselves as human beings who deserve compassion and nurturing (Emde & Robinson, 2001, pp. 265 -266).

This support may be offered in the clinical situation by interpreting the emotions of the infant to the mother. It may also be necessary to process more deeply the mother's background and primary interaction models and traumas to achieve some psychic space for a mother to reach her infant's emotions and to mirror them (Kalland & Maliniemi-Piispanen, 1999; Harel et al., 2006; Cornell, 2008; Nylen et al., 2006).

Insecure parents may also need practical, *behavioral advice,* or *psycho- educational knowledge* to enable positive interaction with the infant. Supporting the parents in focusing on the infant's needs and individuality may give them an opportunity to strengthen the emotional relationship with and commitment to the infant.

The emphatic relationship between the therapist and the parent enables processing on the "zone of proximal development" (ZPD) of the parent. Vygotsky (as cited in Crittenden, 2008, p. 17) describes this to be:

> *"…kind of set of competencies that are emerging for a given individual at a specific moment in time. It reflects the unique variation in what each individual, of any age, is ready to learn next."*

To support the parent to work on the infant's "zone of proximal development", the therapist has to be able to work on the parent's "zone of proximal development". This requires a perspective to both the mother's and the infant's ZPD.

2.3 Mirroring and Communication Emphasized Music Therapy

Mirroring is an old concept, which was introduced by Kohut (1971, 1977). He illustrates the interaction between a mother and her infant, and the way the mother is mirroring the baby`s emotions, expression and existance. Austin (1996) compares this to musical interaction and reflection. Pavlicevic (1997) defines mirroring essential in musical interaction in music therapy. Bruscia (1987) describes in his 64 clinical techniques of improvisational music therapy some categories, which are related to early interaction between a mother and her infant. *Synchronizing* is a technique, which includes doing same thing at the same time with the client. *Pacing* includes matching to the client's energy level. *Reflecting* is based on matching to the moods and feelings of the client. *Exaggerating* consist of amplifying client's response or behavior musically. (Erkkilä, 1997.)

Heidi Ahonen-Eerikäinen (1998, 1999) compares the Daniel Stern`s (1985) concept of the "vitality affects" to musical interaction and communication, which both have their emotional contents but yet no words. Musical phrases, crescendos, diminuendos and accelerandos are kind of qualities and shapes that are also the foundation of a communication by a baby. She describes a music therapy process as a process for "making the baby visible" , which has a firm relativeness to Stern's phases of infant's self's development.

In her dissertation, Heidi Ahonen-Eerikäinen (1998) describes Communication Emphasized Music Therapy process, which begins in musical encountering and making contact by musical mirroring at the same arousal level as the client has. As a "good enough mother" (Winnicott, 1953), the therapist interprets as communicative an activity which the client does not yet mean to be communicative. This mirroring is awakening the client to contact. According to Ahonen (1999), this has connections to Stern's (1985, pp. 47-64, 100-123, 124-161) idea of increasing self-awareness and self-expression of the infant when "emergent self", "core self" and "subjective self" are growing up. When a client recognizes the possibility to be in contact by playing, s/he begins to test his influence to the therapist through this activity.

According to Ahonen-Eerikäinen (1998) the client starts taking the initiative in his improvisation and tests and ensures, that he is able to influence the therapist, as an infant ensures that s/he is able to influence the mother. The client starts to act like "the boss" in the improvisation and apparently enjoys the effect of his/her self-expression. Little by little the client begins to be more turn-taking in

the improvisation and starts to adopt the "rules of dialogue" (Stern 1985). The adoption of the" rules of dialogue" is the phase where the subjective self is already rising.

2.4 Challenges in Recognizing Infant's Emotions

An infant needs an experience of mutually constructed meanings shared by her/his mother (Harel et al., 2006) This requires from the mother an ability to synchronize her feelings and actions to a suitable level for her infant and to inform the infant in right timing, that s/he has been understood (Schulman, 2002). This may be challenging for mothers, especially if they have difficulties in recognizing their own feelings and emotions due to their psychic state, a crisis or painful experiences in their own history or primary families (Harel et al., 2006).

Berg Broden (2006) and Fonagy (1994) have described how essential it is for a mother to have the ability for self-reflection in order to strengthen and deepen their relationship with their infant. Self-reflection is essential for parents in order to avoid transferring overwhelming emotions to the next generation. It supports the mothers to feel separate from their infants and to identify infants' emotions more clearly. That demands the ability for insight process with imagination and playfulness. The possibility to express their feelings gives mothers an opportunity to avoid expressing them through depression, anxiety or psychosomatic symptoms and to be more present for their infants. (Broden, 2006.) Musical improvisation may serve as a chance to express diverse feelings broadly (Ahonen-Eerikäinen, 1993, 2007).

2.5 Emotions and Music Therapy

Daniel Stern (1985, 1992, 1995; Stern & Bruschweiler-Stern, 1998) has compared the inner world of an infant to music. Due to the musical nature of infants' expression it is natural to support the interaction of mother and infant with music. Music may offer an opportunity to approach a wide range of an infant's inner experiences. (Carlsson, 2007; Lipponen, 2002, 2003, 2005, 2008, 2010, 2012, 2013; Salo & Tuomi, 2008; Burke, 1996; Oldfield, 1996.)

It has been illustrated in the theory of music therapy that music may offer a connection to the pre-verbal earliest developmental phases of a human being (Stern 1995; Ahonen-Eerikäinen 1999; Salkeld, 2008). Even adults may reach important early developmental phases and feelings that originate from the period before the verbal outcome existed. According to Sinkkonen (2001) a baby has developed some kind of an attachment strategy before the age of one. Music may reach these pre-verbal phases also after this attachment has developed.

The interaction between the therapist and the client may closely resemble the interaction with the earliest objects and may offer a possibility for repairing experiences concerning them (Kenny, 1991; Scheiby 1998; Ahonen-Eerikäinen 2007). In cases of insecure attachment strategies, there may be experiences of early shame, traumas or poorly timed interaction (Broden, 2006; Sinkkonen, 2001; Salkeld, 2008). The possibility to nurture those earliest pre-verbal phases with musical interaction, adequate timing and emotional holding may offer access to the treatment of the earliest attachment strategies

2.6 Early Interaction Music Therapy (EIMT)

Music therapy is based on musical interaction. Early interaction consists of many musical aspects, so it is natural that many music therapists have influences of early interaction in their work with clients even though they wouldn't call their work as early interaction music therapy.

Early Interaction Music Therapy (EIMT) is defined in International Dictionary of Music Therapy (Kirkland, 2013):

> *"(EIMT) May be seen as one part of baby science-based music therapies. EIMT is informed by infant development science, early interaction research, attachment patterns and treatment applications. EIMT is based on Stern's (1985) theory of vitality affects that serves as a framework for understanding infants' ways of experiencing and expressing themselves. Vitality affects are musical in their nature and thus music may be an important tool for reaching and making contact during the earliest phases of human development (Ahonen-Eerikäinen, 1999). EIMT is sometimes based on solution-centred, supportive methods but usually is rooted in psychodynamically oriented methods concentrated on the primary caregiver's inner imaged of the infant (Carlsson, 2007) or primary attachment*

experiences of the caregiver (Lipponen, 2008). Treatment may also benefit from the implementation of Early Interaction Assessment tools, such as the Care Index (Crittenden, 2007) or the Marshak Interaction Method (Marshak, 1960). One goal for EIMT is to find suitable dynamics, tempos, and nuances for the primary caregiver's improvisation or mirroring of the infant to foster mutual contact, communication and enjoyment (Lipponen, 2008). EIMT may also involve elements of Theraplay (Booth and Jernberg, 2010), inviting the therapist to support the primary caregiver by offering care, structure and emotional support through music (Lipponen, 2005). (Auli Lipponen)

Carlsson (2007) has investigated early interaction and music therapy in her thesis in Finland. Music therapy work has also been assessed in another master thesis in the context of early interaction video assessment procedure, the Care Index (Tuomi 2004), and there are two doctoral dissertations to be completed from same authors. The emphasis in these studies has been in the development of mother's inner representations of her infant during the music therapy process and in the aspect of the development of attachment behavior in music therapy process of a one-year-old child.

In this study, the concept of early interaction music therapy is comprised of two music therapies: early interaction music therapy for mother-infant dyad and mother's own music therapy process involved. Early interaction music therapy refers to music therapy work for a dyad or groups consisting of dyads which aims at supporting or changing the attachment strategies that dyads have. It has a psychodynamic background which manifests itself in the conceptions of early experiences' influence to attachment strategies and to both infants' and adults' emotional and interactional traits.

Early interaction music therapy also has psycho-educational aspects when supporting the adults to attune to and reflect their infants' emotions and actions. Some aspects of early interaction music therapy are used in the mother's own music therapy. Many of the issues processed in the mothers' own music therapy derive from the dyad music therapy. Concerning the parents' own music therapy process, there are common music therapy methods, such as musical mirroring and emphasizing techniques that are used to support the mother. These techniques have a strong connection with early interaction communication and with the concept of Communication Emphasized Music Therapy. It also involves psychodynamic processing, which is not present in the dyad music therapy to the same extent. The mother's own music therapy process strives for processing her emotional issues, potential crisis and her developmental problems that relate to the challenges she faces when trying to cope with the needs and emotions of her infant.

3. AIMS OF THE STUDY

According to current studies, it seems that Music Therapy is a medium of treatment which has remarkable essential qualities that make it suitable for early interaction treatments. As a tool which offers a pre-verbal world to express the emotions that occur in the earliest phases of development, it may prove itself to be a suitable form of supporting or treating both infants' interaction and mothers' earliest interaction experiences.

It is still not established whether the mother's own experiences of being musically mirrored and reflected in music therapy could support her to reach better the emotions of her own infant. This study aims at investigating whether the mother's own therapeutic processing could support her to get in contact with her inner feelings and to see her infant more clearly and improve the early interaction between the mother and her infant.

Mäntymaa (2006) reports that the mother's childhood memories of her own upbringing were associated with the quality of her prenatal attachment towards her unborn baby. Also the mother's prenatal attachment towards the fetus has been associated with the quality of early mother-infant interaction later.

In the early interaction work in the field of child protection, one of the challenges is to find an effective way to influence the preverbal, unconscious developmental phases of a mother. Many emotional or family crises influence the emotional availability of the mother. Also many of the infants in child protection work are withdrawn from contact and unwilling or unable to communicate. This study aims to investigate music therapy as a processing method for these kind of challenges.

4. RESEARCH METHODS

4.1 The Implementation of the Research

This study investigates two music therapy processes, one which relates to the mother and infant dyad and the other to the mother's own music therapy. The therapy sessions were executed concatenated during the same day. Mother-infant dyad's music therapy was first in the morning after which the mother had her own music therapy session. Both sessions lasted one hour.

Both music therapies were delivered in 15 sets, mostly once a week. The father was invited to participate in one early interaction music therapy session in order for the therapist to investigate the musical interaction in the triad of a mother, infant and father. In the middle of the process due to the upcoming holidays of the family, sessions were organized twice a week.

The mother was 42 years old, she had a long relationship with her husband; they were married and had just their first child. They had contacted doctors on neurological department because of worries concerning the infant. According to the parents their infant had had strange symptoms since three months old. Her eyes were sometimes rolling and she was masturbating. Neurologists didn't find any concerns and sent the family home. They became customers of a family counseling unit because the masturbating didn't decrease although other symptoms did.

The family counseling unit recommended music therapy for the mother and the infant because the mother's own music therapy could be organized as a part of the present study. The mother had lost her father recently to cancer, her mother had died a year ago and she had also recently lost her grandmother with whom she had been close. She had a treatment relationship in the family counseling unit, but it was suspended for the duration of the music therapy.

4.2 Research Methods of the Case Study

4.2.1 Abductive Research

Professional experience creates expectations and assumptions on the development of music therapy process and influence of interventions. These factors are not excluded from scientific research based on clinical work. Abduction is a suitable framework for the present music therapy case-study, because it is grounded on unverifiable assumptions and it reflects and interacts with the empirical perceptions of the data and theories. The clinical experience and knowledge offers the researcher a framework for interpreting and explaining the perceptions in the process, but the interaction with the theories and the data may also create new, surprising facts and definitions. (Ahonen, 1998; Peirce, 1965.)

The hypothesis which was the guiding principle in this study was developed from an intuitive knowledge based on clinical work experience. It guided the researcher to focus on certain issues and circumstances in the music therapy processes and data analysis. The assumption was that they would create new ideas and notions to produce new knowledge or theory about clinical music therapy work. (Peirce, 1965.) Careful examination of clinical work may help to better focus the interventions and practices. The aim of comparing these therapy processes was to identify effective interventions which support the mother to adjust her interaction with the infant. The mother was supported to improve her dynamics more responding to the infant's dynamics by musical improvisation and therapeutic discussion. Tracing these kinds of interventions may help music therapists to allocate their therapeutic interventions appropriately to benefit the wellbeing of both the mother and the infant. Thereby this kind of research may also serve as action research for creating new, more effective and better functioning practices for clinical work. (Kemmis & McTaggart, 1988.)

This research is a qualitative case study which is based on abductive inference. The emphasis is on the perception, reflection and interpretation of two music therapy processes. According to Ahonen-Eerikäinen (personal communication, May 22, 2012) qualitative research is "appropriate for studies which have their emphasis on processes". Qualitative research aims at exploring and understanding human behavior, conceiving the meanings and interpretations humans make instead of performing descriptions numerally (Pyörälä, 1995).

This study is grounded on clinical experience of early interaction music therapy. When researcher is herself a music therapist in the process, it is clear that she is remarkably involved in and inside the interaction. Willig (2008) challenges researches to profound reflexivity upon the ways the researcher is involved in the research context and data:

> *"Reflexivity means more than acknowledging personal "biases", (it) invites us to think about how our own reactions to the research context and the data actually make possible certain insights and understandings"*
>
> (Willig, 2008, p. 18).

Especially within qualitative studies of therapy or psychology, the researcher's deep insight should be extended to the demanding and critical level:

> "*...reflexivity in qualitative research has much in common with how psychoanalytic psychotherapists see "countertransference" – the therapist's emotional response to the client's behavior – in order to gain a better understanding of the client"*
>
> (Willig, 2008, p. 18).

Reflexive attitude due to the researcher's personal and professional implication to the research context doesn't exclude profound investigation of data or/and remaining open to the possibility that the research question may change during the process due to the results and material risen up. (Willig, 2008, p.15; Ahonen-Eerikäinen, 1998.)

4.2.2 Phenomenology and Triangulation

Hermeneutic phenomenology in this research means accepting the fact that the interpretations of the music therapist and her awareness of the area under investigation constitute an integral part of the analysis. Avoiding all presuppositions and biases while exploring a phenomenon is something that phenomenological researches seldom assume. Interpretative phenomenology "does not separate description and interpretation" (Willig, 2008, p. 56). Phenomenological research is context bounded and open for change, because it emphasizes to the human entanglement to the world (Purola, 2000).

This study uses *triangulation* to examine the same phenomenon with the combination of different methodologies (Denzin 1987, pp. 291; Janhonen & Nikkonen, 2001, p. 31). Jick (1979, p. 602) suggests researchers have a possibility to improve the "accuracy of their judgments by collecting

different kind of data bearing on the same phenomenon". This qualitative research includes quantitative data collection method (Thurmond 2001, p. 254). The assessment method used, i.e. the Infant Care Index, measures infant-parent interaction by numeral coding. It gives information about the sensitivity of parent and the co-operation skills of the infant. In this study the focus is in the development of interaction during the process. It involves pre – and post - coding as well as an assessment of the father-infant dyad in the end of the process. In this research, triangulation means exploring early interaction and emotional contents by using different perspectives of musical interaction, early interaction assessment, early interaction theories, infant development theories and psycho- and music therapy theories.

This research contains two case studies, which are investigated and compared. Case Study Research focuses on understanding and describing these "*processes within its real life context"* (Woodside, 2010; Yin, 1994, p. 13). In this abductive research the music therapist is due to her professional knowledge and education deeply involved in the interventions and outcomes of the therapy processes. According to Yin (1994, p.13), the case study method is suitable for inquiring phenomena especially when the "boundaries between phenomenon and context are not clearly evident".

In this case study the purpose is not to find typical causalities but to describe phenomena and make new perceptions. The reader may, - and the researcher will, nevertheless consider the results and make generalizations or draw parallels to other objects. (Writing@CSU 1993-2012.)

As Heidegger indicates:

> *"We call the development of our understanding an interpretation…In interpretations we don't catch knowledge of the understood, but it means that we become conscious of the possibilities that our understanding projects".*
>
> (Heidegger, 1972.)

4.3 Methods Collecting Data

4.3.1 The Care Index

The Care Index is an early interaction assessment procedure based on DMM (Crittenden, 2007). In this study, the assessment is based on the Care Index Infant Coding Manual (Crittenden, 2007). It can be used with infants from birth to 15 months. Care Index is the best validated DMM assessment in low-risk populations but it has been quite commonly used as an assessment tool for example in child protection work with high risk families in Finland.

Farnfield et al. (2010) explains Care Index as a play based system, which is designed to assess the dyadic synchrony between the attachment figure and the child. The interaction is videotaped for 3-5 minutes with an instruction to the parent to "play with your baby as you would usually do". In this study the Care Index videotaping was conducted in the family's apartment, pre- and post-assessing the interaction of the mother-infant dyad and post-assessing the interaction of the father-infant dyad.

The interaction is assessed according to the sensitivity of the parent and the co-operation of the infant. Both are coded from the other's perspective. For example, if the mother is constantly pushing the child or demanding things from him/her, she is coded from the infant's perspective as "controlling". If the infant is resisting and repeatedly looking away from the parent, s/he is coded as "difficult" from the parent's perspective.

The infant is coded according to four patterns of behavior: cooperation, compulsivity, difficulty and passivity (Farnfield et al., 2010). These behaviors are observed through seven different sectors: facial expression, vocal expression, position and body contact, arousal and affection turn taking, control and choice of activity (Ahlqvist & Kanninen, 2003). The behaviors that signify each of these four categories in those seven sectors are described in detail in the Care Index Manual. (Crittenden, 2007.)

The parent is coded according to three signifier behaviors: sensitivity, control and unresponsiveness. These behaviors are also observed through same seven sectors as in the infant's coding (Ahlqvist & Kanninen, 2003). Coding provides a 14 point global risk assessment scale, where 0-4 points in sensitivity or cooperation yields a classification labelled "at risk", 5-6 points a classification labelled "inept", 7-10 points a classification labelled "adequate" for parents and "mixed cooperative" for infants and 11-14 points are considered sufficient (Crittenden, 2007, p.7). The Care Index tells

much about the parent's contribution to the child's strategy, because the adult acts as an active participant in the assessment. (Farnfield et al., 2010).

4.3.2 Clinical Observations on the Care Index Factors and Musical Interaction

According to clinical experience, there are some connections between interaction and the type of musical improvisation. Controlling parents seem to improvise dynamically louder, they don't listen to the infant's phrasing, and they may have difficulties in mirroring changing dynamics and details of the infant's improvisation. It has proved useful to support them to become more sensitive to the details of their infant's improvisation. If the parent is very passive, the infant may be hyper-active and overwhelmingly expressing her/himself with louder dynamics and faster tempo. Clinical practice has shown that it is useful to support this kind of a parent to intensify her dynamic and expression to reach the expression level that is present in her infant's improvisation.

When the parent has been assessed as unresponsive but intrusive, - as is often the case with clients with personality disorders, s/he may be quiet and absent from the infant's improvisation when the infant would need to make contact, but intrusively controlling when suitable for the parent. In this case, the parent benefits from a support to be more active in her/his unresponsive periods and instead of intrusiveness, increase predictability in her musical reflection or mutual play, for example by using crescendos and diminuendos more consciously.

If an infant is very passive, s/he should be mirrored with exaggerating dynamics and precise phrasing to invite him/her to make contact. When infant is over active, s/he needs structuring elements, such as rhythmical continuity, but also exciting variances of sound and pause as well as interesting instruments, such as ocean, spring or candy drum, to share an experience of self-regulation and patience to reach something interesting and exciting.

All of these approaches have a behavioral background, and it is also important to investigate the psychological history and reasons for the specific coping/interaction system used by the mother. Usually, it is necessary to process different expression polarities and their challenges in the mother's own music therapy. It is common that a non-responsive adult has a background of having an arbitrary parent in her primary family. The mother has not had the possibility to exist in her own primary family in some expressive polarity. An adult who is controlling in her expression, may have had a

parent that has not taken enough responsibility and she may benefit from a trustful and steady relationship within music therapy. These parents may be mirrored and reflected in their own challenges and supported to have the courage to step to a new expressive world.

Clinical observations according to the quality of the early interaction and the connections to the musical expression and psychodynamic history:

Early Interaction	**Musical Mirroring**	**Mother's improvisation**	**Primary Family**
Controlling mother	Overwhelming, phrases not synchronized with infant's expression,	Challenges with silent expressions, sensitivity and rhythmical synchrony	The mother has been faced with a demand of having to be too responsible too early
Passive mother	Quiet, passive, no initiatives, not catching the infant's attention	Low tempos, quiet dynamics, few initiatives	The mother has been faced with a demand of having to be "invisible" in her primary family.

5.3.2 Videotaping and Description

All 30 of the sessions were videotaped and their description was first made in Finnish and then translated into English. Meaningful therapeutic moments were gathered according to the mother's processing, the infant's development, the mother-infant interaction, mother-music therapist interaction and infant-music therapist interaction. Meaningful improvisations and verbalizations were analyzed and theoretical connections were drawn. Counter-transference feelings were written down during the process and the description phase.

5. AUTHOR'S PROFESSIONAL EXPERIENCE AND CLINICAL MODEL

This thesis is based on my ten years of experience of clinical music therapy work in the field of child protection. I studied the details of early interaction music therapy work with mother-infant dyads on my bachelor's degree dissertation. I educated myself on early interaction video assessment methods, such as Early Relational Assessment, ERA (Clark, 1985); basics of Emotional Availability Scales, EAS (Biringen, 2000); Baby-MIM, Marshak Interaction Method (Marshak, 1960); and took a clinical one-year reliability and supplementary courses of the Care Index, Infants (Crittenden, 2007). I have been using all of these assessment methods in my professional clinical work as a part of treatment and assessment of early interaction and parenthood during the past ten years.

Throughout my professional life I have been interested in different therapeutic frameworks and their influence in the process of therapy work. On my bachelor's degree dissertation I investigated different frameworks which have an impact on early interaction music therapy inside the triad of mother-infant dyad and the music therapist.

In my experience it would seem obvious that the phenomena in early interaction music therapy cannot be interpreted by one single framework. My working context in open welfare child protection with high risk families sometimes requires quite strong guidance, teaching and confrontation. At the same time my own framework of psychodynamic music therapy did not allow me to restrict myself to behavioral and psycho-educational aspects only. The backgrounds of the mothers occupied my mind and their history became apparent in their challenges to respond their infants' needs in adequate ways.

I became more and more interested in the primary families and attachment objects of the mothers'. As I had given music therapy to the mothers separately too, it became increasingly obvious that special kinds of interaction patterns often had plenty of connections with the mothers' experiences of their primary families and the interaction inside them.

As a music therapist I couldn't avoid recognizing that many of the interaction patterns and challenges were connected to a special type of musical improvisation and expression. I saw many mothers struggling in musical dynamics at the same time as they moved towards a wider experience and expression in their own interaction. The chance to express themselves in a supportive atmosphere with varying musical dynamics seemed to conjure up painful memories from their history. They used music to struggle towards their potential expression and space and used improvisation to express painful emotions and memories that arose in that context. (Lipponen, 2008.)

Having the experience of being mirrored and reflected in their musical expression in their own music therapy process supported the mothers to step into the rich and dynamic improvisations of their infants. The more they were familiar with their own needs and emotions, the more they were able to meet and contain their infants' needs and emotions in an adequate way. (Lipponen, 2008.)

It became clear that it was not enough to support the mothers to assume a playful and containing interaction with verbalizing and teaching them of their infant's needs. Nor was it enough to mirror the infant in musical improvisation if the mother was not able to attend the polarities of the infant's emotions and expression. During my clinical practice in child protection I developed a music therapy model for early interaction work. It was aimed at considering the needs of the infant, at supporting the mother in mirroring the infant and at processing the needs, deprivations and traumas of the mother. This thesis is an attempt to widen my professional understanding of the influence and meaning of a mother's music therapy process and to investigate and describe the working model in detail.

The working model is comprised of two music therapy processes: the mother-infant dyad's music therapy and the mother's own music therapy. It may be observed in three crucial acts that are involved in the processes:

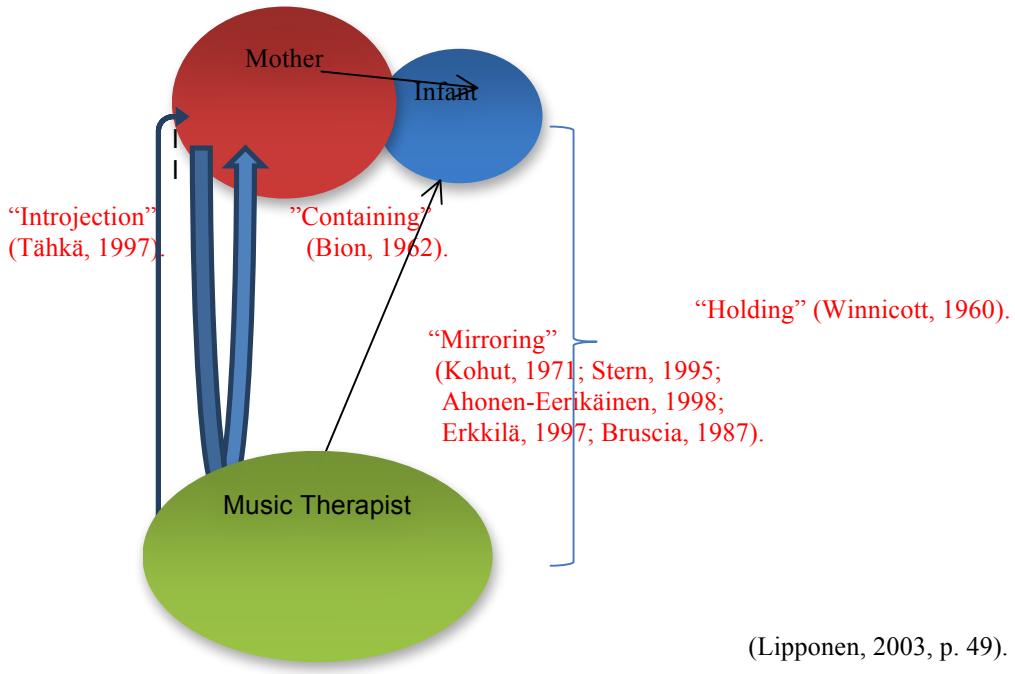
1. mirroring and reflecting the infant visible and self-expressing
2. supporting the mother to adjust to her infant's expression and needs
3. processing the needs, challenges relating to musical expression and traumas with the mother

5.1 Psychodynamic and Music Therapy Framework

In terms of *psychodynamic framework* early interaction music therapy may be seen as a range of acts, emotions and expressions that are aiming at creating new psychic internalizations of containing, sensitive and regulating parent in a holding therapeutic atmosphere. (Ahonen-Eerikäinen, 1999; Bion, 1962; Lipponen, 2003; Stern, 1995; Tähkä, 1997; Winnicott, 1965.) The therapist is *containing* simultaneously the infant's and the mother's emotions and feeding them back in a "bearable" form. This also includes the *holding* of the mother's anxiety of the infant's needs and emotions (Lipponen, 2003; Winnicott, 1965). In this context, *sensitiveness* to the infant's needs means synchronizing the adult's acts, improvisation and expression so that the infant may get an experience of his/her message being noticed, interpreted, answered and timed correctly (Berg Broden, 1989; Lipponen, 2003). *Regulation* of emotions and acts emerges in musical improvisation, mirroring and reflecting of the infant's expression so that she/he can feel safe in different kind of expressive polarities and have the experience of being able to control emotions and return supportively to a calm basic tempo and "being" (Lipponen, 2008; Wake, 2010, p. 116; Schore, 2003).

Different expressive polarities sometimes appear to be even more challenging to some mothers than to infants (Lipponen, 2008). *Introjection* is happening in the music therapy process when the mother is internalizing emotions, expressions, excitement regulation and self-regulative functions from the therapist (Lipponen, 2003, p. 49; Tähkä, 1997, p. 99).

Psychodynamic and music therapy framework:



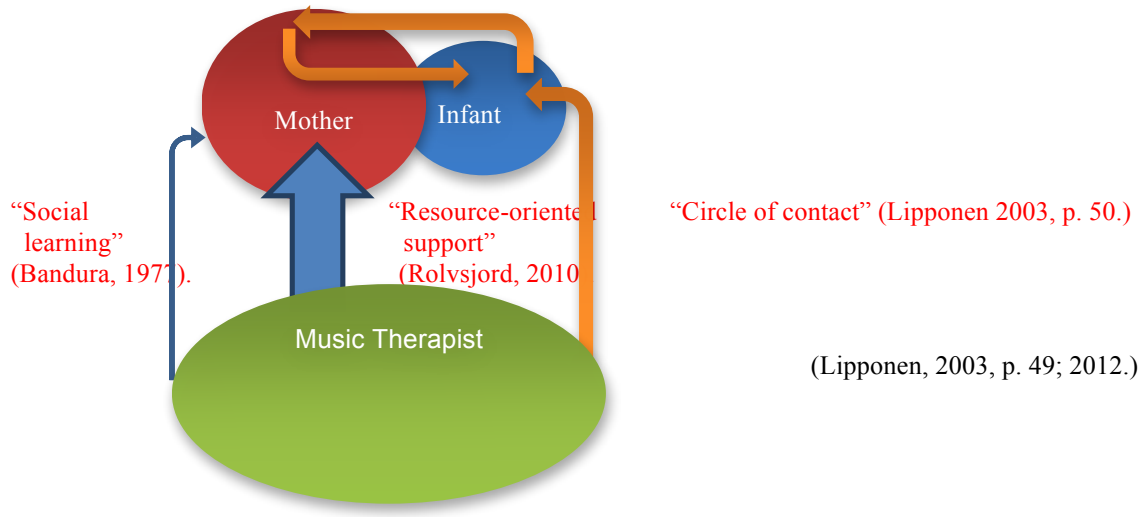
(Lipponen, 2003, p. 49).

5.2 Non-psychodynamic Frameworks

In terms of the behavioristic frameworks, early interaction music therapy may be seen as a range of acts, emotions and expressions that are aiming at creating new psychic skills. It is necessary for the mother to adopt traits that are needed for understanding, acting and timing the behavior so that the infant and the mother are able to make a connection and synchronize their interaction. Mothers may be supported and taught to mirror their infants. The approach is directive towards the parent but highly non-directive towards the infant. Mothers learn adequate timing and dynamics for the interaction by social learning from the therapist. Psycho-educative and cognitive frameworks aim at offering knowledge about infant development and motherhood, in addition to straighten perverted thinking internalizations. (Bandura, 1977; Dowd, 2002, p. 17; Lipponen, 2003, 2008; Sanderson & Rego, 2002, p. 235.)

Many mothers need experiences of successful interaction which give them more trust in their motherhood and ability to respond to their infant's needs (Kalland & Maliniemi-Piispanen, 1999). Music therapy supports the mothers to reach the playfulness and to bear the experience of shame of being childish. That is especially challenging for young parents which have barely passed their own childhood. Resource-oriented framework may offer tools for strengthening the mothers and encouraging them to trust themselves and to step to playfulness (Berg & Miller, 1994; Lipponen, 2011; Rolvsjord, 2010.) Often it is necessary to invite the infant to the contact and joy by the music therapist. After that is achieved, it is common that the mother receives the joy from the infant and it becomes their mutual experience through a "circle of contact" (Lipponen 2003).

Behavioristic, cognitive, resource oriented and music therapy framework:



(Lipponen, 2003, p. 49; 2012.)

5.3 Psychodynamic and Trauma Based Framework

According to clinical experience, mirroring and reflecting the infant visible and capable of self-expression has not been enough to create adequate interaction between mother and infant. Nor has the support that the mother has been offered been enough to make the mother to adjust to her infant's expression and needs. The challenges of stepping to the infant's expression and especially the polarities of it seems to demand more individual processing of the mother's emotions and barriers preventing it.

In music therapy literature it has been reported that musical image may act as a transference or trauma reconstruction (Ahonen-Eerikäinen, 2007, p. 115; Bruscia, 1998, p. 426.) In child protection, early interaction treatments often involve some kind of pressure of demand towards the mother to be able to respond to her infant's needs in an adequate way in order to avoid custody. In the behavioral parts of teaching the mother to mirror and reflect her infant's expression and to adjust to her infant's needs there may also be a lesser demand of stepping to challenging expressive polarities that are not familiar to the mother. These polarities may act as transference or trauma reconstruction for the mother and they may therefore expose mothers to their traumatic history. Exposition to a painful event in a symbolic level with music, may, up to a point, be used in a trustful and safe therapeutic relationship as a trigger to processing traumatic history of a client. (Odgen, Minton & Pain, 2009, p. 250).

Early interaction treatment may be the first context where the mother is faced with demands of structures or nurturing and care which she may not even herself have experienced in her own childhood. The therapist may be forced to set herself in a position of "bad mother", who demands acts that are difficult and stressful for the mother (Uusitalo et al., 2005, p. 34). Also other psycho-educative aspects of infant and motherhood development, shared in the music therapy, may trigger the processing of the mother's own past experiences and deprivations in it. The knowledge of the infant's needs arouses the mother's own anger, losses and sorrow from her own childhood and she may begin to experience compassion for herself as a child. (Lipponen, 2008.)

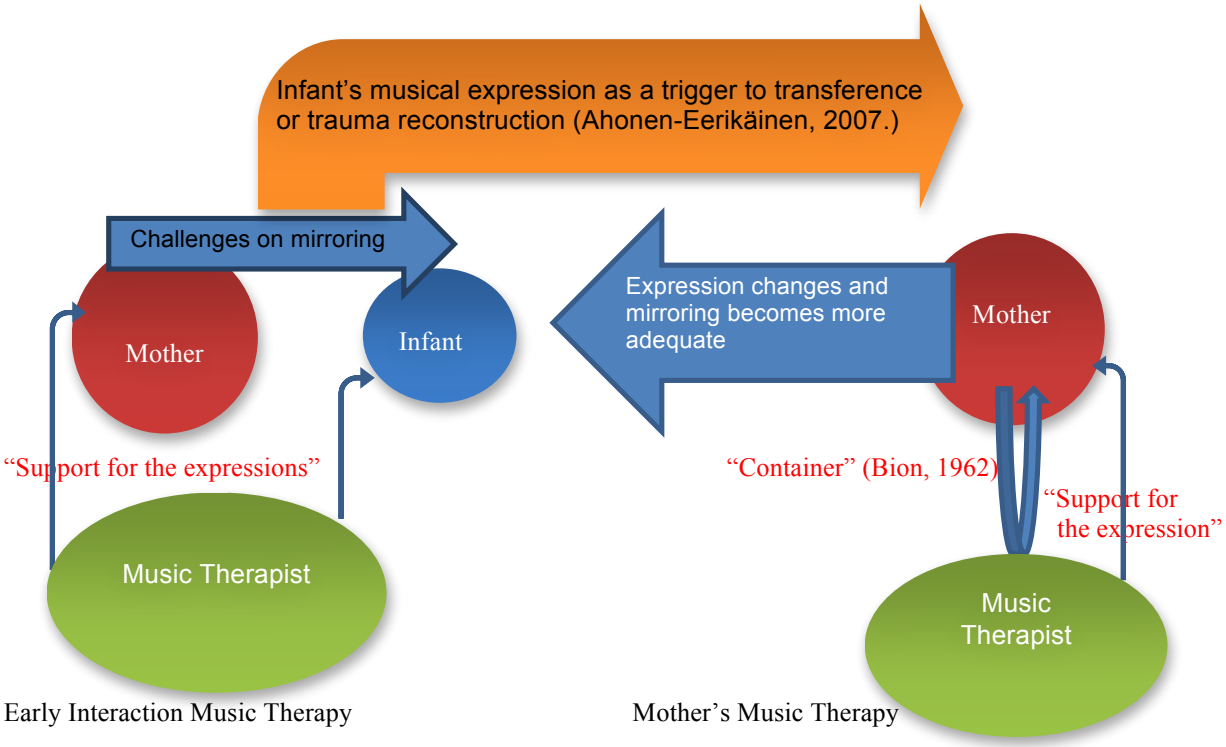
It is challenging to support the mother to bear the emotions and to be able to function in the context of motherhood at the same time when processing her sometimes traumatic relationships in her primary family. (Suokas-Cuncliffe 2005, p. 80.) When it has been discovered that motherhood in itself activates the mother's unsafe attachment pattern, it becomes quite clear that some kind of

individual support is needed in child protection high risk family treatments (Lipponen, 2008; Tamminen, 2001, pp. 234-249). Creating enough sensitivity to meet the infant's needs may demand a safe therapeutic relationship to process the mother's own attachment figures. (Crittenden, 2008; Hautamäki, 2011; Lipponen, 2008; Uusitalo et al. 2005.)

Essential in the mother's own music therapy is that the therapist is repeatedly able to empathize the subjective and externalized emotions of the client. Therapist actively offers sufficient support with words, improvisation and other descriptions which gradually help the client to bear and to deal with the traumatic situations and memories. Trustful relationship with and relience in the therapist and identification with the therapist's competence of tolerating and controlling is essential for the mother to process her painful experiences. (Ahonen-Eerikäinen, 2007; Schulman, 2002, pp. 178-179.)

The figures below demonstrate the phases of the music therapy early interaction model and describe the framework of them:

Early Interaction Music Therapy v.s. Mother's Music Therapy



Early Interaction Music Therapy

Mother's Music Therapy

6. CASE STUDY

6.1 "Masturbating Infant and Distressed Mother" (Infant-Mother Dyad Music Therapy Sessions 1-5)

In the beginning of the process, the infant masturbated a lot and she turned quickly serious after the occasional little smiles. She had quite a lot of initiatives but she was changing the focus of her interest often. She was able to make contact, even take some pleasure and interest in mutual playing, but in a qualified manner. She laughed without sound and was often not easily invoked to make contact. She rejected many initiatives especially from her mother, although she was getting closer to the mother when insecure. The infant became increasingly bubbling and vivid during the sessions. It seemed that musical mirroring had started to strengthen the self-expression and initiatives of the infant (Ahonen-Eerikäinen, 1999).

The mother seemed serious, tired and resigned in her interaction but acted kindly and gently towards her infant. She hugged the infant almost clinging to her and talked to her in a pitying voice. She brought up her tiredness, worries and memories of the time when the infant had just been born describing herself as having been so tired that she had said to the newborn:

> *"…now mother is so tired, that she can't even bear you anymore…"*

The music therapist was trying to mirror and reflect the infant's initiatives intensively to induce her to interaction. The mother was supported to *intensify and exaggerate* her dynamics to reach the infant (Bruscia, 1987; Erkkilä, 1997). They shared minor moments of mutual joy and relaxed encountering. However, after even the slightest frightening trigger those moments of joy were easily turned into a situation characterized by the infant's increased masturbation, seriousness and immobile body accompanied by the mother's worry and anxiety. In body-based songs the infant didn't participate in the interaction at all. She was stony-faced and motionless or feeling uncomfortable in her mother's lap and constantly striving away from it.

The therapist's *countertransference* feelings were total worry, anxiety and panic. It seemed that the infant had gone out of contact and was totally shocked by something.

At the very end of the first third, the infant started to create more sounds, initiatives and to hug occasionally spontaneously the mother.

6.2 "Grieving Mother" (Mother's Music Therapy Sessions 1-5)

Mother's improvisation in her first own music therapy session was *non-referential*, with the sole instruction to play something that she wanted to express, to try and test her feelings and the instruments she had available. Ahonen- Eerikäinen (2007, p.69) describes Bruscia's (1987) definition of non-referential improvisation as "built purely around the sounds themselves", not based on any specific issue, idea or concept outside it.

Her improvisation was soft, quiet and sad. She was stroking the djembe drum's skin and crying. Her verbalizations after the improvisation illustrated the pain and fear of losing her infant that was growing apart from her. She was remembering the first phases of her infant's life, comprised of plenty of the infant's crying, overwhelming needs of the baby and barriers it brought to daily routines. She was afraid of her infant coming down with cancer or some serious disease as has happened to members of her immediate family that had passed away. She began to talk about her feelings of *guilt* when she couldn't be with her departed mother as much as she thought she should have been in her last days of life. She told she was wondering if the situation was same concerning her father's death too and if she should have done something differently.

The mother brought up her concern of *not giving enough support for the infant for her not to masturbate*. She thought she had to offer many stimuli to entertain her baby. She talked about her *husband and the peremptory* of his. She felt herself as a person without so much knowledge and complained about being often *alone* with the baby's masturbation symptom at home. When her husband was present she described herself as kind of an assistant in her home. She assumed that it was easier for her husband to tell negative things but not to discuss them very openly. Her husband had a positive attitude to her own therapy process, and thought that she would need that to ease her feelings. As an *expression of desire of being comprehensively accepted*, she described:

M: "… it feels, like there is all the time something to correct,….my mother always considered everything I did usually kind of good and I received… always a word of thanks…nowadays I receive more …that I always do something… wrongly, and even though I do something right, I don't get any feedback of it…and now I think it would be kind of the most important thing for me to be a good mother for the baby, but even that feels that I don't get any…. "

The mother illustrated her *father as a person who expected accomplishments* to accept her, and not as an altruistic person. Although she felt that her father had approved later on her decisions which hadn't been in accordance with her father's hopes and views. She didn't remember her father crying until in the last days in the hospital where they had cried together. She told that she found a more sensitive side of his father at the time. She had tried to take care of her father, newborn baby and summer cottage at the same time last summer. After this discussion therapist suggested improvisation and the mother's answer was:

M: "Do I have to play?..."

T: "If You feel, that You don't want to, You don't have to…can You reach what just happened to You? Can You reach the feeling?"

M: "Can I play…. it is little a bit like some kind of accomplishing,… like there would be some barriers…"

T: "Maybe we could play those barriers, how do they feel?"

The mother experimented restlessly with different sounds by twiddling and knocking a rain stick. The therapist was reflecting her with djembe by keeping a quick and stable rhythm behind, but searching different tones, too.

M: (cries)"Somehow it feels I like playing but at the same time I am struggling against.. music kind of gets me free of that bad feeling and I begin to be in a good mood… kind of polarities, that I can't play that way… that it would sound beautiful,- beauty which I can't produce……..I have never brawled…it only increases a bad feeling, it has never eased my feelings…"

Not diagnosed depression may be seen in the mother's description of her sadness:

"…is it ever possible to be happy again? So that I wouldn't worry so much about everything?... that sadness kind of stays on.. so that you can't get rid of it…"

To animate the memories of love and acceptance of her departed mother, the referential improvisation's instruction was named "Perfect girl". After playing with a Finnish zither and glockenspiel a folk song-like, quiet, calm and sensitive improvisation with stable rhythm, she described her feelings:

"It feels good even in my fingers and such a beautiful song, it felt good that I was capable of it…"

The mother begun to process her tendency of *not being able to express her anger* when something was bothering or annoying her:

M: " I swallow everything because I'm thinking that it creates a wrangle if I don't … and I want to save my baby from it… so I bite my teeth and say nothing…just yesterday I had a situation where I started to cry, but I couldn't say anything… then I just stay there.. I'm just so bad on showing my anger…"

The therapist suggested an improvisation about the things she would like to tell or the feelings that she would want to show her husband.

The improvisation was in very quiet dynamics, whispering and rhythm cut to little pieces with a diminuendo in the end.

M: "(cries)...kind of letting yourself to be yourself…. but so many difficulties me and my husband have seen and experienced together… we are kind of stronger…respect…from both sides.. worries about the baby's health made us closer, but then the everyday routines come again…"

T: "… were the everyday routines that were more connected to that disrespectful behavior?"

M: " yes, yes…"

T: "What did you say with your improvisation to you husband?"

M: " That he should listen to me…"

The music therapist's *countertransference* feelings were confused. The image that the therapist had got from the improvisation was different from how the mother verbalized it. Did the mother actually not have aggression to express or was she really too inhibited to bring it out?

> *M:"The car trips are difficult, because my husband gets anxious about the infant's masturbation, - which increases in the car, and he kind of blames me for not being able to do anything about it...it kind of takes the guilt away from him… it feels unfair because I have so many other things to bear too…my dearest people have been taken away,- who could support me, away from me…I'm thinking about my loneliness"*
>
> *T:" Can we play that loneliness?"*

Referential improvisation (Ahonen-Eerikäinen, 2007; Bruscia, 1987) was used to animate the mother's images in an improvisation. In referential improvisation the music therapist gives to the improvisation a subject or a theme which the client or the therapist considers essential or worth of deeper investigation. This intervention aims at picking up significant meanings for the client from the material that s/he is producing.

This referential improvisation rose up from another referential improvisation, which was based on the Fritz Perls' (1973) technique of "empty chair" grounded in gestalt therapy, where the client is expressing her/his feelings towards some important object by addressing them to the imagined person or object sitting in an empty chair opposite. The chair was not physically present, but the mother was guided to express with music her repressed feelings towards her husband and supported to steer herself to recognize, express and understand her emotions better.

The music therapist highlighted the feeling of loneliness from the mother's verbalization of her improvisation. Its aim was to experience deeper and more profoundly this meaningful emotion that the mother was expressing in her improvisation through subsequent combination of externalization and internalization. The mother's improvisation, which externalized her non-verbal emotions was internalized by processing the outcome in her mind and then the externalized verbalization of the expression was again externalized in a new referential improvisation, named by herself in her first verbalization. This technique deepens the processing of an important issue or phenomenon and gives the client the opportunity to investigate it from different perspectives (Ahonen-Eerikäinen, 2007).

The mother chose the glockenspiel and played experimentally, quietly, changed to piece xylophones, played for a long time very gently and listening. Rhythm was divided to smaller parts but the tempo was not very fast.

M: "(cries)"..kind of emptiness…that kind of things,- what has once been, has disappeared, but I don't know if anything has replaced it…the emptiness is kind of booming there.."

T:"Was that your feeling when you were playing?"

M:"…little a bit, - kind of meandering there, at home…at first there was this certain time of the day when I started to wait for my husband to come…but it has changed…I don't kind of wait anymore… so that I have given up… I kind of protect myself, so that I will not be disappointed when he is not coming… it may be six or eight o'clock … you can't know… "

As an intervention of supportive technique, the sessions usually ended with structured and hopeful music helping the mother to move on to an adult parenthood with her infant. She described the music listened by illustrating her own growth:

"I heard…growth, development, own voice, which was found.."

The mother was worried about having been sick last week. She was wondering if her infant had been afraid, when she had only lied on the floor her eyes shut. The infant had been with her father all week until now when the care had changed to the mother. It seemed that the girl was crying when separated from her mother. That was a new phenomenon and there was reason to believe that it may have been a signal of attachment and of the deepening of the relationship between mother and infant (Bowlby, 1959).

Therapist and mother were talking about the months immediately after the birth, when the mother had been mentally and physically absent.

M: "About three months of that terrible crying… They were, - those days, completely full of crying…. The first two weeks the baby was very calm, - at home, two weeks she stayed calm, and then on the third week when the father was still at home, the crying begun and when he started working, she was crying for three months…when I stayed at home with her… we cried all day long…"

T:"Did you cry, too?"

M:"Once in a while, yes.."

T:"What were you crying for?"

M:"For not being able to help her…. horrible despair… felt like a bad mother because I couldn't help her…it felt that nothing kind of… although I tried to feed her…was she in pain or hungry…. She was not clinging to me a lot… otherwise but she was not accepting to be on the floor at all… she only approved my lap… but she didn't show me that kind of… kind of… just wanted to be in my lap… but didn't any way kind of…."was it really hard for my girl, those days in the beginning?"

T:"Maybe the two problems were feeding each other… the more your baby cries, the more that little crying baby inside you is kind of waking up and you kind of can't get support from that mother of yours…"

M:"I couldn't ask advice from anyone… I couldn't soothe my own baby and nobody was able to comfort

T:"To offer some empathy for you?"

M:"Yes, yes.."

The essential interpretation for the mother from the first months of the baby's life was something that we came back over and over again in the process later:

T:" Your baby may act this way… when you have been extremely sad, it may be, that the baby doesn't want to look at you, because she knows, that it makes her feel bad...the baby can't , -kind of, distinguish that emotion from her own feelings… so, if you feel bad, the baby gets the same feeling, she can't defend herself from that…and it may happen, that the baby doesn't look at you… when she feels the insecurity…. and wants, therefore, to be in your lap all the time. If it feels that the mother is not present, if she kind of takes care of you being present by keeping herself near you physically… so that may have been her reaction to your sorrow… "

"But at the moment, she doesn't act like that anymore… she comes to your lap for a refill and is ... worried that you would disappear… she is in contact and able to walk here and there…so the first fears have disappeared…"

"Nobody is able to offer only the best for their baby… you can't offer the absolute good.. only very few have it so that there wouldn't be anything…when you have this tendency of reproaching yourself...it's not so perfect with anyone else either… you have had that sorrow… the baby has reacted to that… and it increases your anxiety…all the mothers whose babies have had colic disease, and they get tired and think that they don't have the strength to support the baby enough… and when life goes on… you can't always control life …you can't know where it leads you… and you have such a nice girl there who is able to come to contact with little inducing… I saw kind of strengthening in you… things will get repaired…"

M:"I feel kind of better now….maybe it is… I don't know how it is but last time when I talked about those feelings of injustice at home… it feels like he listens me more… some effort anyway… they don't come so easily anymore, those invalidating comments...it feels kind of easier…."

The mother was also beginning to bring up the guilt of not being present enough in the earliest phases of her infant's life. In the fifth session, the mother seemed relaxed and pleased until the end when the infant was frightened by loud music and begun to masturbate and drew herself from contact. Mother brought her feelings of disappointment up. She connected infant's behavior to the newborn times at summer cottage:

M: ".. she seems to feel bad, kind of goes to her own world to feel better… kind of I couldn't be able to create a good connection with her… so that something drives her there, kind of wanting to go away there…the summer was certainly a bit like that… I kind of tried to cover everything... was I not present enough for her? I kind of tried to take care of everything…and she was not so much close to me anymore… as in the beginning…"

In the end of the first third, hope begun to arise. The mother described her experience of listening music at home:

> *M:"..I listen to music quite often… I heard a piece, which made me feel very good.. somehow… it hasn't been so for a long time… it woke me up… the intonation.. the guitars were so positive…"*

Reflection:

The anxiety of having experienced important losses could be recognized during the process. Especially in the first sessions there were plenty of *separation anxiety, longing, sorrow, even regression to the earliest phases of the mother's own development*. The mother was mirrored and reflected in her first, most sensitive djembe improvisations. She got the experience of communicating with the music therapist at earliest vitality affect levels (Ahonen-Eerikäinen, 1998, 2007; Stern 1985) and receiving comfort and holding (Winnicott, 1960) for those emotions.

According to Jun et al. (2007) women who lose both their parents during a 5-year interval, show greater increase in depressive symptoms and declining happiness and self-esteem. They are also reported to create a lower level of personal mastery and psychological well-being. This mother was expressing her sorrow, lack of happiness and low expectations as a mother and as a wife.

Umberson (1995) emphasizes that parent loss can also affect marital interactions and quality. This mother had experienced her husband's behavior as rude and underestimating, but had nevertheless received from him strong support for attending her own music therapy process to resolve the problems related to prolonged sorrow and joylessness.

She also processed her losses in relation to her infant. She described the experience of being alone with the anxiety of not being able to comfort her baby when she was crying. The endless crying of the infant is unbearable for many parents. Freud (1918) describes projection to be a defense mechanism whereby undesirable feelings are projected to someone else. Although the endless crying of an infant is challenging for many parents, in a situation where the mother is suffering from a severe fear of losing her own parents, it may multiply the effect of despair in a sense of projected own feelings of despair and of the inability to help her own parents suffering from a decease.

In music therapy, there is a possibility to process these projections by using musical improvisation. This mother heard *this loneliness, despair and loss in her improvisation* and could also verbalize it to

the therapist. She processed her emotions at a level of projection where according to Heidi Ahonen-Eerikäinen (2007) she hears the music sounding “like me” or as ”my feelings feel”.

According to Abeles et al. (2004), the death of an adult’s parent in the context of family with an infant, is in most cases the loss of a grandparent. In these cases, they consider it advisable that these families are offered support by family life educators and practitioners.

Kissane & Zaider (2010) separate different states of loss and sorrow:

- *Bereavemen*t as a state of loss resulting from death
- *Grief* as an emotional and psychological response associated with loss, intense sorrow and physical, cognitive, behavioral and social dimensions (Watts, 2010, p. 60.)
- *Mourning* as a process of adaptation, including the cultural and social rituals prescribed as accompaniments

In the first sessions the mother was mostly experiencing the loss and the grief. She expressed her grief with intimate and profound improvisations, which included images of her dead mother’s touch and care. According to the cultural and social mourning process, the mother had an immediate history of the cultural and social rituals, having had funerals of her father and the ceremony at the urn cemetery at he time she was starting the music therapy process. Although she had adapted to a certain extent to the loss of her mother, the grief relating to her departed father also arose a painful longing towards the care of her mother. The birth of her daughter and due to that, a natural psychological need to be in contact with older women with an experience of motherhood, - especially her own mother, was drawing her towards the ones she missed although the mourning period of her mother’s death had lasted for months (Stern, 1998).

According to Bowlby (1959) our earliest attachments are essential in how we cope with different kinds of lossess in our adulthood. The loneliness of the mother may be interpreted as a “separation anxiety” of an internalized meaningful object and fear of being without the dead person and an infant in early developmental phases. The needs of the mother were very regressive and also in some degree obviously directed towards her infant in an image of longing after the closeness and bonding of the infant towards her. She also seemed to manifest her needs of comfort and support by answering to her infant’s diverse needs by sadness and comfort seeding behavior repeatedly.

Byng-Hall (1995) described how a therapeutic relationship can provide a client, - as a healthy parent-child relationship, a temporary secure base to make the necessary exploratory steps to recovery. This mother turned out to be able to enter the therapeutic relationship. Simson & Rholes (1998) report how the secure attachment is "manifested in the tendency of seeking support when coping with stressful experiences". This mother was secure enough to use the availability of the music therapist to relieve and comfort herself in her own music therapy process. She used creativity to process the loss and the grief.

Hägglund (1991) describes how the pain of losing a meaningful object, which has offered drive- and social satisfaction, can be eased and expressed in creative work. Creative experience may create experiences of giving and receiving and therefore reduce the feelings of loneliness and separation. The mother expressed a reconstruction of a traumatic event through her musical expression (Ahonen-Eerikäinen, 2007, p. 144). She verbalized her loneliness in the early phases with her infant at home. She also processed her loneliness of being a woman and mother without support from her parents which she had just lost.

Freud (1926) and Waelder (1960) have illustrated that infant's separation of mother and mother's love is creating anxiety of subjection for separation which may be manifested in a symbolic death fear. This mother expressed her fear of her infant growing apart from her or coming down with cancer as her parents. She processed her fear and anxiety of separation through creative experiences by improvising or processing her inner images of music. Winnicott's (1974) concept of transitional object is comparable to creative experiences where the client is able to process fears of separation and complete loneliness and on the other hand have an experience of being able to integrate and assimilate to others. In later developmental phases creativity marks to the client the understanding of his/her individual uniqueness but also an acceptance of tradition that exists. (Hägglund 1991, p. 28.)

The music therapist has to be emotionally available, offer predictability and accurate empathy to create an atmosphere where the client is able to enter painful emotions (Byng-Hall, 1995). The therapist's lesser amount of guilt increases the mother's opportunity to express her *guilt* and *anxiety*, and helps the therapist to be an object that the mother needs at that exact moment (Hägglund, 1991, p. 28).

The mother described the memories of her father had expectations for her to succeed in certain *accomplishments* in her life. This theme arose also in her relationship with her husband and also in

her fears of the music therapist's expectations regarding her accomplishments in musical improvisation. The atmosphere was safe enough for her to enter these fears by improvisation and she played the feelings of being inhibited to do something due to anxiety caused by those expectations. The mother seemed to have quite idealized images of her deceased mother and also high perfectionist demands towards herself. These traits, - being characteristic of depression patients´ images of not being accepted when not being able to live up to their ideals, would suggest that the mother was actually suffering from undiagnosed depression due to the great losses she had recently experienced. The music therapist supported the mother to understand the basis of her unreasonable expectations of being a perfect mother and helped her to estimate her goals and appreciations in a broader context (Lindfors, 2005, p. 167).

6.3 "Turning Point " (Infant-Mother Dyad Music Therapy Sessions 6-9)

After the sixth music therapy dyad session it seemed obvious, that the infant already remembered many of the mutual musical plays. She made initiations towards starting mutual plays that she had shared before. She showed signs of shared humor by doing funny things such as putting a mallet in her mouth and shaking her head afterwards. At this point of the process the music therapist could occasionally observe the infant starting to masturbate but changing the intention into a mutual musical play.

The infant was more active and cooperative with the therapist, but the initiatives she shared with her mother were mostly interrupting her mother's actions or taking instruments from her hand.

The countertransference feelings of the therapist were mostly sadness and empathy for the mother for trying hard and being present for the infant who was constantly rejecting her.

The last session of the second third of the dyad was a turning point in the music therapy process. It became clear, that *the infant didn't masturbate at all in the therapy*. The mother told, that they had changed roles with her husband for supporting the girl to take the mother also as somebody who takes care of different daily routines.

M:"Recently in the mornings I have done the morning wash...and he has then fed her sometimes. "

Surprisingly in the interaction session, - where the father was present, it occurred, that the infant had already absorbed the mutual play with the mother. She directed more initiatives to the mother although she turned to the father when worried or scared. It seemed, that the mother was able to be present even longer for the infant even though the interaction with the father was also smooth and active. The last session of the second third of the music therapy process gave the impression that the contact with the mother had increased and the infant enjoyed for a first time also of musical plays with her body.

Reflection:

According to Freud (1910), an infant is capable of feeling sexually pleasurable experiences even during the sucking age. Infants are also experiencing the desire for repetition of those feelings to "establish the future primacy of these erogenous zones for the sexual activity". It seems although that in this case, when the masturbation is frequent, compulsive and occurs in the situations where the infant is frustrated, irritated or confused, it is pointing to the possibility, that there has been an early deprivation according to attachment when the infant has been under five months old (Salo, 2011).

Hyrck (2009) is reporting Bick's (1988) idea of "second skin" which an infant is creating in a form of exanthema when the mother is repeatedly not sufficiently available in frustrating situations. An infant may also lean on other external targets, for example on some sensations already known. An infant is able to replace the dependency from the mother by using some substitute that eases the infant's state, keeps the infant's self together, and experience it as representing safety, continuity and familiarity for a moment. (Hyrck, 2009.)

If the masturbation symptom of this infant had connections to this kind of deprivation, it is comprehensible that musical mirroring and emotional presence in the infant's slightest initiatives influences the symptom by diminishing or stopping it. The fact, - that masturbation was diminishing and ceasing during the music therapy sessions, - points to the conclusion - , that the intensive interaction and mirroring of the infant at musical level was compensatory response to the needs that were in the background of the compulsive masturbation.

In his book "Playing and Reality", Winnicott (1971) points out, that "when a child is playing, the masturbatory element is essentially lacking". He even claims, that when a physical excitement of instinctual involvement becomes evident, the playing stops. Lehtonen (1986) describes musical improvisation as a potential, transitional space for psychic processing and imaginative play, as well as Winnicott (1971) consideres child's play as an expression of creativity.

According to Stern (1995) the vitality affect level of communication is similar to musical expression. In music therapy there is the possibility to have contact and to communicate at those earliest levels of development (Ahonen-Eerikäinen, 1999). The intensity and timing of musical mirroring and reflection may offer repairing experiences related to the infant's earliest phases and, therefore, it could be assumed that music therapy may have a place in the field of attachment treatments.

6.4 "Hope" (Mother's Music Therapy Sessions 6-9)

The mother started to process her feelings about the infant's attachment to the father:

> *M:"It feels… bad that in father's arms she feels so comfortable that she wouldn't want to leave him, and from my arms ,there is no crying, when I…give her, like to her father… but in the other direction she cries…."*

After the improvisation *(Mf):*

> *M: "I found that voice a bit, …kind of air or something….I got a great aunt .. who had a very rough life… but I can always remember that lovely laugh of hers… it came from such deepness…it felt so good… seeing things in little situations… crying, but immediately that laughing also…"*

The mother was processing the jealous feelings about her infant being considerably attached to the father:

> *M:"I really easily… draw myself to the background… it hit me again, that in every circumstances my girl cries immediately when her father leaves… it feels so bad.. what does it mean, that although we were here together… she*

cries after her father?… as it just was… no crying when they left me…it doesn't feel same for her.."

She improvised in more loud dynamics, even brought some dissonances to her playing. The therapist played structure behind her playing, reflecting with her dynamics. In the verbalization of the improvisation she begun to show signs of hope and processed strongly her primary family relationships:

M: "My mother was really empathetic… on the side of the weak ones…(cries).. it came from her, that I think it is important to stand up for the weak ones…I have always kind of been some kind of listener…. "

"My mother was the eldest of her siblings… she didn't take much space for herself… she was more an aggregating force…she gave me space as a person… I sat in my grandmum's lap until the age I was really grown up…grandmum liked to keep me in her lap…

"*Dad was more of a story teller… he took more space… he kind of changed softer when he got older, showed more of those soft traits…. he had got that kind of upbringing, that it is not allowed to show feelings… not allowed to cry… Anyway I have cried a lot … he said that there is nothing to cry about here now... irritated… "*

"*I'm always the one to whom my friends can vent their feelings… I couldn't bear that anymore at all… I have a bad consciousness when I don't feel up to be in contact… I don't feel up to explain anything… it feels so rough to go to my working place in front of those strange people, - being so broken that I am now…"*

"*…my sense of responsibility is always arising …"*

"*.. day before yesterday we took the urn of my father and put it beside the one of my mother… there both of them… terribly missing them.. both…I want to believe that it is not everything here… that there is something after this earthbound…that some period has now ended…that responsibility.. there is no-one to share it with…"*

The therapist was vivifying how it would be if her mother took her infant into her arms and by doing so was supporting the mother to internalize the sensitivity and care of the grandmother as part of herself with her infant. In this point of process, the music therapist returned to first improvisations, where the mother was touching and stroking the drum…

M: "(cries)..Especially that she would take my baby to her arms so often and take care she was very handy making food...that physical contact…from there it has become… hugging… my baby has now begun to hugg me little by little…"

"...On the other hand my father kneaded my feet always..."

M:"There was a situation,… - I became very sad..., that I kind of succeeded to tell him, that he behaves kind of underestimating way… not appreciating…the girl is learning to behave that way towards me too… I kind of succeeded to tell him…"

T:"Did it ease your feelings?"

M:"Yes… yes"

After the symptom of masturbation had ceased in the context of music therapy, the mother decreased the processing of the *guilt and shame* related to the symptom.

M:"Somehow you kind of just wait when it (masturbation) emerges again…that where it turns up from again…"

"I was ashamed of that… they were awfully little, - those circles of us…it was so tearful that life...I kind of couldn't cope anymore…some elder women came when my baby was crying … the despair when standing in the street corner again and finding myself thinking how are we able to manage home from here.. the majority of the days went like that…"

The therapist returned to the mother's improvisation which she had described illustrating the loneliness and the emptiness of her life.

T:"...When you played and told that the walls are booming of loneliness…with fears and sorrows… the whole world... it would be hard for anyone… anxious…you are quite strong not to have gone to some psychotic state… you feel sorrow, which is a healthy emotion…your mental strength is quite good…"

M:"… I think of those first days when it was very rough for both of us, me and the baby… but somehow she is like more joyful nowadays…I have more joy within me…I'm not doing things only mechanically anymore … I exist…it feels good to be kind of awake..."

In this third session, mother's improvisation was culminating to a three quarters light waltz-rhythm with Boomwhackers-set. Her playing had a great power of expression, she was laughing from time to time and the dynamics were varying to stronger polarities. She was describing her improvisation:

M:"It just felt so funny… it started to bounce… it felt nice… pulled me kind of upwards…it was funny…kind of physical experience which pulls me up…it felt so nice to play… It is just a lighter feeling… the music takes control of me….a totally good feeling"

Along with the increasing strength and joy, the mother could also process her guilt relating to shame and sorrow of the lost moments with her daughter:

M:"it feels bad that I couldn't have been... I wouldn't want to somehow force my baby to be something else that she is… to give her permission to be as she is…"

M:"I've been thinking that… I was so happy when she was born.. but I find it difficult to reach that feeling now…I was quite exhausted last summer…it felt so difficult to arrange the christening…terribly worried about her symptoms…tired and worried…that when she was crying I was that kind of…I was thinking that I have no worth as a mother… I can't calm my baby down…she doesn't feel good with me… we were waiting for daddy to come with the bus and he didn't come…"

Reflection:

In the middle of the music therapy process the mother's improvisation started to include more dissonant nuances. She begun to process her relationship with her father and mother. She recognized the diversity of the roles between her mother and father. It reminded her of the roles in her present family and the back ground of the experienced problems of lacking the space and freedom of expression at home. It seemed that that musical improvisation and the verbal processing were raising important issues from her childhood. These problems of being able to take her own space and sound in interaction could be recognized in her way of interacting with her infant in dyad music therapy. She begun to consider her role and be encouraged to take more space at home.

6.4.1 Psychodynamic Framework in Music Therapy Process

Bruscia (1998) describes the *transference* in musical improvisation or listening experience to be an experience of listening the music to "tell a message, emanating from a significant person in client's life". This mother experienced her mother's comforting hands and presence in her improvisation. She begun to process the characteristics of the roles of her primary and present family after the improvisations. Ahonen-Eerikäinen (2007) explains how for example the level of transference is comes up in the music therapy process: *This music reminds me of my mother"* or : *"This music sounds like my childhood home"*…(Ahonen-Eerikäinen, 2007, p. 135). Music may stimulate images and memories and offer an expression for feelings which are difficult to verbalize (Bruscia, 1987).

According to these arguments it can be considered that in this phase of the music therapy process this mother was processing her childhood roles and atmosphere at a level of transference. It can be suggested, that due the processing, she begun to change her role at her present family and home and that processing could be heard in her dynamically more lively improvisations. According to Bruscia (1987) the analytical music therapy model provides essential means of differentiating and integrating inner and outer aspects of the self for the client. This mother started to differentiate her roles and her new state of mind and integrate her increased energy level and better atmosphere through her improvisation.

In the beginning the images of the mother's own mother where idealized and the grandmother seemed to represent an entirely "good object" (Klein, 1957) with endless love and care. The

depression and guilt had their own influence on this idealization to take palce. It was necessary to strengthen images of safe objects to cope with the traumatic situation of the deaths of the near relatives (Huopainen, 2002). Yet, little by little the mother begun to have memories of her great-aunt, who had overcome great difficulties in her life and regardless of that maintained a bigger-than-life laugh and energy. This figure seemed to represent *hope in a hard life situation*. The picture of her demanding father got warmer nuances and the mother begun to see life with a *future and hope*.

Her strengthened condition and the disappearance of the symptoms of the infant may have increased her feelings of hope. She could also begin to admit the feeling of shame related to the infant's symptom and to integrate her guilt regarding her emotional absence in the earliest phases of her baby's life. The integration of the different sides of her personality and history increased.

In music therapy, the holding images of a dead grandmother arose and were also purposedly vivified by the therapist. Mikulincer & Florian (2000) report that securely attached persons react to mortality salience with transformational and constructive strategies. They aim to solve the situation by investing in their children's care and engaging in creative, growth-oriented activities whose products will live on after the death. The aim of vivifying the memories of the grandmother, was to create a continuum of the grandmother's holding and care in a form of emotional heritage and internalization in order for the mother to offer it to her infant.

6.5 "Mutual Representations and Joyful Expectation" (Infant-Mother Music Therapy Sessions 10-15)

On the tenth dyad session the music therapist could stay in the background in the improvisation-mirroring part and to let the mother-infant interaction carry on *autonomously*. The mother got instructions to exaggerate her expressions to get suitable dynamics for the infant's quite expressive playing. The mother played peek-a-boo with the infant and the infant was spontaneously hugging her mother. If the infant didn't participate in the interaction, the mother was persistently and caringly continuing efforts. The infant started increasingly to take *eye contact* with the mother and their interaction was functioning without the help of the therapist. The infant was cooing interactively and lightly with the mother.

The challenge of synchronizing the mother's mirroring to the improvisation of the infant was not in their different dynamics. It seemed that the mother's quiet, passive nuances illustrated her own feelings instead of her effort of stimulating the infant. It seemed that the mother had a need to be comforted herself and this diversity in the dynamics did not originate from the mother's primary family interaction, but rather from the present losses and sorrow she had had in recent years up to an almost traumatic scale.

The music therapist had some kind of intuition of the mother's interaction problems without reaching the actual issue in this phase.

> *T:"You are talking to her as you wouldn't believe that she hears you…you say things to her but you are not kind of addressing them to her…if you have that idea, that she doesn't approve you… that those things that you are offering to her are not good for her… There are actually things that infants don't know better…"*

The mother felt sad about her infant's parental behavior towards her:

> *M:"..Yesterday when we were at our summer cottage… I began to cry… my child was in my sister's lap and they came there and my infant tried to… kind of… comfort me in my sorrow… it felt kind of bad…"*

At the eleventh dyad music therapy session the infant was more active from the beginning. The mother tried hard to catch the infant's attention, failed and her infant rejected her. This created strong countertransference feelings in the therapist's mind. Feelings of heaviness, frustration and failure filled the therapist's mind. Strong compassion to the mother's efforts was present. The music therapist noticed that the mother was filling playful situations with some kind of sad pity for the infant regardless of the content of the play. Her interaction with the infant included hardly any situational comic or spontaneously shared joy. The therapist got the impression of an overwhelming sadness and guilt regarding the unsuccessful moments of their mutual path and a desperate attempt to compensate them.

Little by little the mother and the infant were starting to find common ground in their interaction. They shared increasingly lovely moments and common interests together, especially during some "blind spots" in the session. The therapist gave room for that and they shared mutual gentle cooing and mumbling occasionally.

The piano improvisation proved successful at times. The infant was expressing herself in a rich way, using different polarities, dynamics and tempo. She was playful and pointed different objects and succeeded in creating mutual songs of them. Mother begun to find her playfulness and sang strongly together with the therapist to verbalize the things that the infant was interested in.

At this point of the process the girl was active, playing expressively and returning to a repertoire which had been created during the process. She begun to *remember* different play experiences and it seemed that the therapist, the mother and the infant were sharing mutual representations of the events and occasions that had happened during the session. This created a *joyful expectation* and memories of emotional content. She begun also to take support and help from the mother

The mother described the infant's past manner of not getting involved in playfulness, - especially when sitting in her lap, in the music playgroup earlier:

> *M:" the others are excited… but she hasn't been too excited… she can't at all .. I'm like.. the others start to jump…she hasn't been exited at all.. It started in January.. the music playgroup continued all spring.."*

The therapist made an observation of the infant being limp, - especially from her feet, in the therapist's lap. She became very serious and didn't start or receive any initiatives. That situation brought questions of possible deprivations and even doubts of sexual abuse to therapist's mind due to her history of working in child custody.

The infant had previously been investigated by a neurologist and also by a pediatrician and no doubts concerning that area had arisen. In addition conversations with the family welfare clinic's treating psychotherapist didn't confirm these doubts either, nor did the emotional presence of the parents, who were worried about the symptoms of the infant.

The mother reached *blarney-state of playfulness* during the last third. One of the techniques for supporting the infant to replace her masturbation symptom with interaction was reflecting and mirroring it, but in the way that it was interpreted as some sort of play, emotion or excitement. The aim was to change the symptom to genuine interaction and sharing of emotions. That actually seemed to diminish the symptom and cut it off, and it was replaced by shared feelings.

> *T:"It seems, that she loses the need to go to her own world because she receives something better instead…"*

The mother understood the meaning of connection and communication with her infant:

M: ”So that you wouldn’t have to Pömpiä (=masturbate) all of your own”

In the last third of the process, the mother and the infant found extremely significant mutual play. From a certain play with a “falling” doll the therapist expanded the play to consider the “falling” of the mother. The therapist pushed the mother softly with the doll to get her fall down to the floor. The mother found this particularly amusing and seemed to spontaneously enjoy the play. The infant started to push the mother down with the therapist and the doll, and was extremely interested in what happened with the mother. She fell to her mothers arms spontaneously and they joined to a mutual laugh and joy. This was the first time that the infant took part in a *mutual play with the mother* in a play that consisted situation comedy, spontaneous joy and body contact. The infant was waiting for the play to be *repeated* and enjoyed the mutual happiness.

T:“this was an example of a play where your infant gets an experience of being able to influence the world and people outside… she is so happy when you’re happy…she really wants to be in contact with you… have you sometimes at home played something like this…?”

M: “No, I haven’t… I have not known how…”

This turned out to be the play which proved to the mother that her infant is actually willing to be in contact with her. The problem had been in the mother’s state of mind, which had been filled with sorrow, guilt and self-distrust. In this mutual play where the mother was unremarkedly drawn into a spontaneous joy and whimsy the infant had an opportunity to see her mother from a different perspective and in an emotion that didn’t frighten her. The mother had the possibility to see her infant as willing to be in contact and approving her. They shared strengthening mutual moments which created hope for the future of their relationship. During the twelfth dyad session, the therapist described in her notes the progress of the process as follows:

T:”…The mother receives the girl’s message of turning over the drum… long mutual play here…mother is continuing the girl’s acts really nicely…but the girl is so astonished about it, that looks at the therapist with an inquisitive glance… such a lovely situation! … well done, mother… says at the same time: puuuu… really assertively… the girl is presenting a toy to the mother… now I can see a continuum and mirroring here… the girl and the

mother are playing for a long time…this is a quiet play, - and serious, but the infant accepts the mother as her interaction partner…. "

During the thirteenth session, the dyad was suddenly not in connection with each other again. The music therapist's countertransference feelings according to her notes were confused, desperate and angry:

T:"I can't understand this, the girl seems like a traumatized infant in her interaction with her mother… more contact with the therapist than with the mother… doesn't respond to the mother's initiatives… mother tries again in a new way… the infant's face seems insecure and reserved…the mother… tries hard…the mother is able to stay quite relaxed and calm in her efforts anyway... I get the feeling that this baby doesn't belong to the mother… The mother offers herself, but does not own the baby… the baby doesn't accept the mother… so sad… she doesn't go to her mother, although the mother is playing the falling down- play… this has gone backwards…"

In the end the girl went suddenly to her mother's arms again. The music therapist described the situation:

T:" .. the mother is continuing the mirroring of her infant and the girl is going to the mother's arms suddenly in a lovely way… the mother is grabbing the girl and makes pitying sounds… In the end the therapist is trying to activate the girl but she is difficult to rope in…"

In the last third, the music therapist observed alternations between the mutual interaction of dyad and on the other hand the infant rejecting the mother. Occasionally, the music therapist was able to withdraw herself from the mirroring and playing and observe the turn-taking of the mother and the infant. Mother made many initiatives and created some plays which her girl accepted. The music therapist was reflecting the situation in her transcription as follows:

T: ".. the girl is looking first at the therapist, then at the mother. The mother is asking something and the girls is answering to the mother, who is continuing their conversation… then the girl is feeding the mother… who is not carrying the play forward but is answering yamyam…! The girl is laughing to some of the mother's blarneys and whimsy… actually quite

many eye contacts with the mother…The girl is confirming from the therapist that is it ok to give a respond to that…"

The mother was making up a lovely play. It begun from the infant's initiative of taking her sock from her foot. The girl took the mother's sock too and they created from an upside down turned drum a pot with a concoction where the socks were boiling as raw material. It became a nicely outlined *continuum* of mutual play and innovation.

The ending phase of the process included plenty of *reminiscence and returning to mutual musical plays* and acts to confirm the *mutual representations* which had been created during the process. During these sessions the music therapist facilitated some mutual plays, - not only to mirror and reflect the infant, but also to get an initiative from her to continue the mutual play. As an intervention supporting this goal, the music therapist waited for an eye contact to move on with a familiar and well- liked mutual drum-play. As expected, the girl begun to communicate with her eyes to keep the play going on. The therapist transferred this play to mother and supported her to wait for the eye contact and the infant's initiative to continue the mutual play. This play begun to succeed and the mother and the infant got an increasing amount of mutual joy and tenderness.

The girl acted quite rapidly; she changed the plays and made decisions on initiatives, rejecting many of the initiatives that came from the mother. During one session the girl alternated between rejection and mutual play and between eye contact and turning away from the mother. After the mutual play situations the girl started to resist the mother's new efforts to make contact. The therapeutic challenge was to support the mother to intensify the dynamics to reach the level of expression that her infant had. This, however, made the infant perceive the mother also as someone who was "begging" her attention and caused the interaction to become false. The infant resisted the mother's initiatives from time to time and it was appropriate to support the mother to create some fascinating acts of her own to engage her infant's interest. The mother's overwhelming melancholy spread to the situations, where she was comforting the infant who was angry or annoyed. The infant resisted the mother's comfort and stayed in the angry state of mind longer than would have been necessary in the relevant situation.

The mother was supported to create fascinating acts and to change her focus from attempts to calm the infant in most situations. This seemed to be working. The girl was approaching the mother and joining her acts. The mother used her imagination to create new acts and plays and succeeded to

regulate her daughter's feelings better. It seemed to surprise the infant, that the mother had interests in place of clinging to her or being overwhelmed by melancholy.

The music therapist interpreted the situation to the mother in the last but one session:

> *T:".. do you think that this resistance from your girl could be connected to your own feelings… as you told, you have been afraid of losing her the way you lost your parents… this adherence to her…resorting to her... have you searched from her the kind of protection that you would have needed from your parents in this situation… ?"*

She also received good feedback for her efforts:

> *T:"when you started to have interests of your own, - you got that energy… you got something she wanted to approach…that interest made her almost electric... it invited her… although she was marveled, she was not afraid, she only wondered because it was so unusual of you… you have had these sorrows and maybe a depression…but now you got something that you were interested in!... Children often need parents to have something which they consider important and if they take the child with them also…yes, it is like magnet…this is a new level after mirroring…."*

As an explanation for the infant's behavior, the music therapist interpreted mother's acts:

> *T:"when she is annoyed and angry, you kind of sink to that same feeling… you get stuck to that… but you should leave that state quickly… you have to accept that feeling but especially when she is angry of being limited, it is alright to limit her… and to move quickly forward... just to give her something new in front of her to see so that she can see that something new is waiting there..*
>
> *If you just limit her by taking her to your arms and hold her for a long time… it is unbearable for her... the nice activities are stopping and then you just hold her in your arms… it doesn't change to anything she would like to do…it was so difficult for you... You have to move the situation forward… you didn't do that…*

She should understand that her mother has something else to offer… that it is not supposed to just stay there in that limiting state... that limiting is only one little part of life and now you are returning back to this other nice thing...like you were saying to her, that "If you are not interested, I am anyway!"

Now you were just stuck in that confrontation…as if you would feel so bad if she hurts her feelings and you stay there pitying her… but that provokes her even more! She wanted to act and do things and you interrupted that… she is not sad, she is angry! She is crying out of rage!... You should show her that "Yes, I know you are angry but I'll show you now quickly this other option"…but if nothing else is working, then you'll just have to keep her in your arms… and say that you can understand that she is angry but you can't do anything about that now…

Yes, you really can express these dynamics, these and everything that is needed…"

Reflection:

One of the instructions the mother received, was that of exaggerating her improvisation and mirroring of the infant. The goal was to achieve the dynamic level of the infant and catch the interest of the baby to be in contact with her mother. *Exaggerating* is a technique of music therapy improvisation that is used to emphasize or amplify certain characteristics of the client's expression. In the context of early interaction it is a technique of supporting the mother to induce the infant to increase her self-expression and to convince the infant that her mother is willing to be in contact and communicate with the baby: to mirror and reflect the infant's improvisation's striking timbre, rhythm, melody, interval, contour or phrase structure. Musical mirroring includes the act of exaggerating and mirroring the infant's feelings and present attunement observed (Bruscia, 1987, p. 290, 541; Erkkilä 1997, Ahonen-Eerikäinen, 1999, Lipponen 2003).

The music therapy techniques of mirroring and exaggerating are taught to the mother to support her to create the connection with the infant. The exaggerating provides feedback from the infant, and mirroring the musical elements presented by the client conveys acceptance (Bruscia 1987, 326). Exaggerating is also a technique for engaging the infant in the situation by making a kind of musical

caricature based on a particular quality of the infant's response (Bruscia 1987, p. 371). Infants are specially interested in exaggerating, such as repetition and lengthened inter-phrase pauses, which are common characteristics in playsongs, lullabies and so called "infant directed" speech (Fernald & Kuhl, 1987).

Nancy Suchman (2012) presents the infant's different phases according to their developmental need for mirroring. She reports, that three-month-old infants have a need for "immediate mirroring" to help them become aware of their own emotions. As explained earlier, Heidi Ahonen-Eerikäinen (1999) calls this phase in musical interaction of the music therapy process as a phase of "increasing the self-awareness and self-expression". By being mirrored, infants learn to use this possibility for communication and begin to control the reactions of the nurturing parent. The sense of being self-regulated will arise, although infants are not yet aware of their different emotions or able to orient to the future (Suchman, Pajulo, Kalland, De Coste, & Mayes, 2012.) This phenomenon has a close relationship with Ahonen-Eerikäinen´s (1999) concept of "being a boss" – a phase in communication emphasized music therapy process (Ahonen-Eerikäinen, 1999, p. 27).

After three month's of age the infant begins to prefer an answer which is a bit delayed, but still very exaggerated and underlined (Suchman et al., 2012). In the context of the communication emphasized music therapy theory that is related to the phase when the client is "adopting the rules of the dialogue" (Ahonen-Eerikäinen, 1999).

In this case study, the infant begun to be the "boss" in the musical interaction, but the continuum of the interaction dried up. The infant was activated by the musical mirroring and reflection but it didn't influence the mother-infant interaction sufficiently. The girl was following and answering the acts and initiatives of the mother increasingly, but for some reason the mutual play didn't begin to have continuums.

Stern (1995) describes how, in the infant's experience, the world and daily care situations are temporal experiences which are in relation to musical experiences. They are kind of "temporal feeling shapes" with moments of arousal, expectation and pleasure, for example as in arousal of hunger and pleasure of being fed. According to Stern they are tools for experiencing and structuring subjective time, - in addition to experiencing and structuring feelings, which are represented in time.

Stern (1995) explains how repeated interpersonal experiences formulate to the infant "schemas-of-being-with" another. When being in continuous contact and interaction with a mentally absent

mother, the infant may begin to experience this "schema-of-being-with" her mother in a way which creates a background for disturbed interaction patterns. The infant may form patterns of *compulsive caregiving* or *compulsive performance* to reanimate the interaction with the mother. (Stern, 1995; Crittenden, 2006) If these patterns fail to work in reanimating the mother, the infant may turn away from the mother in order to find a more appropriate level of stimulation. This search for external stimulation may also serve as an act of attachment when the essential attachment object is not available. (Stern, 1995.) In this case it could be interpreted, that this infant had created a *masturbation symptom* as an *external stimulation* which served as an act of attachment when the mother had been repeatedly absent.

Repeated experiences create the basic representations of life to the infant: experiencing-re-experiencing process forms prototypes and generalized models of events (Stern, 1995). In early interaction music therapy, there exist many joyful plays and experiences which are occurring repeatedly during the process. The infants usually begin to wait for *mutual repetitive songs* and plays. This infant began to remember the musical acts and mutual plays in music therapy and she seemed to expect them to recur. Remembering and returning to mutual experiences and the expectations of them being repeated offered the background to the therapeutic intervention of transferring these positive expectations to consider also the mutual interaction with the mother.

One music therapy intervention was implemented in order to increase the playfulness in the mother and to induce the infant to mutual play. Playfulness is an essential quality in the interaction between mother and infant (Winnicott, 1971). This infant had encountered a mentally absent mother with sad eyes. The "schema-of-being-with" the mother for the infant, was imprinted with the mother's mental absence. The aim was that this progressive process of distorted engagement would be changed in the interactional process in music therapy. The pleasurable, repetitive and subjective experiences of mutual play in music therapy were supposed to cover the mother's insight also.

The mother was supported to produce fascinating acts in order to change the expectations of the infant. She was induced to playful state of mind and actually, in the latter stage of the process, was able to express unconditional joy and laughter during the sessions. Seeing the mother being playful and funny seemed to surprise the infant and induce her to the mutual play for a while. The connection between the infant and the mother remained for a moment and the mother gave descriptions of mutual joy experienced even in the following week. The infant was proved to have a *desire of being in contact* with the mother, if the state of the mother's mind was not constantly overwhelmingly sad.

It was needed to convince the infant first, that there was something pleasurable expected related to the mother.

The infant's interest in mutual play and motivation for interaction increased in the music therapy. In the beginning she turned out to be active, but extremely autonomous in her acts. She directed the interaction but was not too co-operative in responding to other's initiatives in mutual play. In the third phase of the music therapy process it seemed, that the situation was secure enough to challenge the infant to increase the turn-taking, co-operation and eye-contact.

The therapist induced the infant to pleasurable mirroring and reflected her until she was motivated to play. The infant was challenged to take eye-contact by interrupting the pleasurable continuum by posing the infant the question "do you wish me to continue" just when the most pleasurable part of the play was to occur. The infant was expected to make eye-contact before continuing the pleasurable play. After even the slightest eye-contact the play was continued and repeated in the same form again. This worked well, and the eye-contact increased clearly. The mother was supported to continue this play and the eye-contact was transferred to occur also between the mother and the infant.

The *working pattern of creating eye-contact* in this music therapy process in a nutshell:

1. awakening the interest in the mutual play
2. the infant begins to show a strong motivation for the mutual play
3. the infant is challenged to make eye-contact before continuing the pleasurable play
4. the reciprocity and interaction is transferred also to the eye-contact between the mother and the infant

6.5.1 Projection

In the last third of the music therapy process of the infant-motherdyad, the playfulness had increased, the mother's melancholy had diminished and the infant and the mother begun to have mutual joy and eye-contact, but it seemed, that the interaction didn't succeed as expected. The infant was still

rejecting her mother and somehow there was still an impression of something not working in the interaction after all.

The turning point of this dyad music therapy was in the latter part of one of the last sessions, when the mother had to limit her infant in a play situation. The infant lost her temper because of the limiting and started to cry angrily. The mother started to comfort the baby by taking her to her arms and soothing her with a voice full of pity. Obviously, the infant did not calm down but got even more furious due to her mother's pitying consolations. The music therapist got a countertransference feeling of irritation and of too slow a tempo of changing the target of attention to ease the frustration. The situation was examined with the mother from the video recording afterwards and the mother got clear instructions to act more quickly and change the target of attention to some pleasurable act to calm down the baby.

At this point the most important finding of this process became clear: *The mother was responding to the infant's emotions but she seemed to respond to a wrong emotion*. It seemed that the mother was pitying an angry child and was *responding to the emotions of fear and sadness, not to the emotions of rage and frustration.* It became clear that she *assumed the infant to have other emotions than those that she actually had.* This raised the question of potential *projection of mother's own feelings to the infant.*

According to Stern (1995) projection may be recognized for example in the mother's interpretations of the infant's behavior. Stern (1995) describes how the mother's interpretations of the infant's intentions and emotions behind them may be so coloured of her own expectations that she is not able to answer adequately to the infant's needs and feelings. The past of the mother may influence her observations in such an essential way that she is not able to recognize the infant's accurate intentions behind the behavior. This may lead to distorted responses to the infant. When continuing in extreme cases it may lead to the phenomenon called *projective identification* where the infant is actually adopting the expectations and creating a personality and a behavior that is correlates with the expectations of the parent. (Grant & Crawley, 2002; Stern, 1995.)

From this point of view it can be assumed, that this *mother projected her own needs of comfort and feelings of desperation to her infant.* She seemed to interpret the feelings of her infant as the needs of being comforted, protected, held in her mother's arms and soothed for a long time. These needs emerged repeatedly in the mother's own music therapy, improvisations and verbalizations and they were derived from her life situation of extreme losses during a short perod of time. It may be

assumed that there was some connection between the mother's repeatedly biased emotional message and the infant's tendency of not willing to receive the initiatives of the mother, - especially in the beginning of the process. It became clear that it was essential to process these needs of the mother to protect the infant from biased interaction and projection.

6.5.2 Transference

As has been explained earlier, the clinical observations illustrated, that in this painful phase of her life, this mother didn't have the psychological strength to interact her infant with adequate feelings, but had a tendency to project her emotions of sorrow to her infant. Although the projection seemed to be her main defence mechanism, there was some evidence of transference feelings towards the infant. In her desire to be comforted in loss and sorrow, this mother seemed to appeal to her environment for empathy and understanding. She explained how she got support and comfort, not only from her husband and sister, but also from her one-year-old daughter.

The ability to empathize arises largely from the nurturing experiences of childhood (Sinkkonen, J. & Kalland, M., 2001). The capability for concern for others is develops during the second year of life. According to Knafo & al (2008), the emotions of empathy require the development of self-other differentiation and emotion regulation. This potential also depends on the ability to take a perspective towards the environment and others (Knafo & al., 2008).

It may be considered a healthy phenomenon of a two-year-old infant to bring forth expressions of empathy towards living creatures in his/her environment when emotions such as sorrow, fear etc. occur. In her aunt's safe lap it was possible for the infant to experience an emotion of empathy towards her mother.

Despite that, it could be observed from the behavior of the mother that she had some expectations of being comforted by her daughter. The projection of the need for comfort to her daughter in a non-adequate situation was manifested by offering a tight hug in a situation which would rather require limiting or structuring. However, the clinical observations revealed a tendency to physically maintain

body contact with the infant by hugging intensively and keeping her in the mother's lap with a sorrowful atmosphere.

The difference between the projective tendencies in the context of interpreting infant's feelings and this observation is, that the mother seemed also to be in need of being physically comforted by the closeness of her infant. She also verbalized her need to be hugged more by the infant although she at the same time had a bad conscience because her infant was trying to comfort her in her sorrow. According to Freud (1940) and Bruschia (1998), transference is a psychological mechanism occurring, when a person is acting in relation to or feeling emotions or expectations towards someone in a way as if this someone was some other person from her/his past history. Transference is considered as a defense when it repeats constantly, - although it stays unconscious (Luukkonen, 2003). From this point of view the interpretation of the mother's need for being comforted by her infant could be considered a transference expectation of the desire to be held by some other important character of the mother's past, for example her deceased mother.

6.6 "Strength, Future and Memories " (Mother's Music Therapy Sessions 10-15)

The mother brought up her strong reluctance of directivity towards her infant in several occasions. In her last music therapy sessions, she processed her own experiences of being forced in some unpleasant way in her childhood. At the tenth music therapy session of the mother she remembered images from her own childhood. They concerned experiences of having been forced to behave in a certain way in her day care family.

> *M:"They forced me to eat there…until I threw up… then they didn't force me so much anymore… I was about five years old…"*

She remembered also some occasions where she had been forced to visit some neighbours of her day care family and strong resistance she had experienced in similar situations later.

In the last third of her music therapy sessions, the mother also described her feelings of her contact with her infant:

M:"Somehow I feel so good… it feels that my girl is now more in contact with me also… there she was waving to me with her Hippu-dog like this…"

T: "Yes, there was so much genuine joy… and she came to hug you!"

M: "It felt so good!"

At this point of the process the mother had achieved more trust in her motherhood and a more optimistic state of mind. She was processing more deeply her past and her relationship to her mother, father and daughter.

6.3.1 Transitional Object

The therapeutic aim of offering the infant a permanent replacing attachment figure when the mother was absent had succeeded. The infant had appropriated the Hippu-dog as her *transitional object* (Winnicott, 1953) and even called the dog with the name her mother had proposed. It may be seen as a representation of the absent mother, - or father, and confirmed the attachment to one important object which hadn't presumably been very strong in the past.

According to Winnicott (1971, p. 3) transitional phenomena may typify a normal phase in the infant's emotional development at about four to six to twelve months of age. It can be an object, behavior or a state of mind where the area of play and illusion exists. Transitional object is a symbol, or substitute for a most important object, - usually a mother, which offers comfort and consolation when the mother is absent.

The infant transfers the attachment and the emotions that relate to the caregiver to some kind of external object, as a doll, a rag etc. Developing a transitional phenomenon for an infant requires from the mother a special capacity for adapting to the needs of her infant. She has to be able to create an attachment that is safe enough to allow the infant to have an illusion that the images the infant is creating, really exist. (Winnicott 1971, p. 10.) This object may help the infant to bare the separation anxiety of her caregiver for a while and give comfort also even when the mother is present for example at the time of going to sleep. At a later age the transitional object or a similar behaviour pattern may comfort the child when deprivation threatens (Winnicott 1971, p. 3).

To create an internal object of the comforting other, the infant has to have an external object that is good enough for this purpose. If the external object fails to be safe or present enough for the infant to create an internal object out of it, the transference object becomes meaningless.

> ” *.. The infant can employ a transitional object when the internal object is alive and real and good enough (not too persecutory). But this internal object depends for its qualities on the existence and aliveness and behaviour of the external object (breast, mother figure, general environmental care)…”*
>
> (Winnicott 1971, p. 7)

An infant cannot make use of the transference object, unless ”the internal object is alive and real and good enough”…(Winnicott 1971, p.7.) If the quality of the maternal care received is not good enough, the transitional object may possibly even take on a fetishistic character, or other pathological form such as drug addiction, lying or theft (Winnicott 1971, p. 4).

This infant adopted Hippu-dog as her transitional object during the music therapy process. She had experienced serious deprivation and a separation from her mother at the age of five months, when the transitional phenomenon should be occurring. *Could it be assumed, that this infant created masturbation as a transitional behavior to bear the separation anxiety of her mother?*

During the music therapy process, along with intensive mirroring and emotional presence she could adopt a new transitional object and enter in a playful atmosphere whereby the masturbation became purposeless.

6.3.2 The Diminishing of the Depression Verbalized from the Improvisations

The improvisation during the eleventh session was peaceful, but going-along, changing to three quarters, flexible waltz-rhythm. The mother was describing her improvisation:

> *M: ”I feel energetic… it feels like I have more strength to say and do things in agreement with my own feelings…I can express my opinion too…when sometimes I felt like nothing matters, that it doesn’t make a difference what I say… that I can… I have found my own will again a little more.”*

"At home, at one point I almost thought that it would be so much easier to give up….and say that it's just the same to me… but I didn't!!!! So good that I didn't do that!"

T: *"Your own strengthening and role… I don't know if you have been in that kind of role in your primary family… at least in relation to your father you had the attentive role...many times people get in relationships which tell something about their role in their childhood… you may hope that this time it will grow and be different from what it was…different from the roles …which you have been used to…*

The mother started to have plans for the future. Overall hopefulness could be seen arising in her images:

M: *"Somehow I have started to think altogether, that what I want to be and do…how does it feel to return to my job...and is that something that I really want to do… I have broadened my thinking… to what is really important and valuable..."*

"My sister changed her line of work and started to study…I have always liked flowers always… that side interests me quite a lot..."

"Maybe it wouldn't be such an impossible idea to go back to work… now when I have this child… maybe my values are a bit different…"

The symptoms of depression are often characterized by negative thoughts of the future, predicting negative results of actions (Gilson et al., 2009, p. 105). According to ICD-10 (2010), during depressive episodes the "capacity for enjoyment and interest is reduced… ideas of guilt and worthlessness are often present". A depressed person may suffer from a loss of pleasurable feelings and marked psychomotor retardation. The depressed person suffers from lowering of mood and s/he may have a general reduction of energy and decreased activity. (ICD-10, 2010.)

According to these definitions of depression, it started to be obvious, that mother's depression begun to decrease. Her emotional development went to the opposite direction of the symptoms of depression during the third part of the process. The mother begun to see her future in a more positive light and she even seemed to get interested in making plans for it. She begun to enjoy her life increasingly and started to have more energy.

6.3.3 Reflective Function

Reflective functioning is related to the representation of the self. Reflective function involves a capacity of distinguishing the inner from the outer reality; intrapersonal emotions and processes from

interpersonal communication (Fonagy, Gergely, Jurist & Target, 2004, p. 25). The reflective function, or mentalization is connected to the infant's interaction with *containing mother* and developing conception of the emotions of self and others. It enables communication and good enough understanding of self and others in social relationships. (Fonagy et al., 2004; Baron-Cohen, 1994.)

It has been suggested, that an insecure attachment style has an influence of reflective function so that parent's past experiences with her/his own primary family are creating distorted interpretations of interactions in present situations. That impairs the ability to separate one's own and other's thoughts from each other. (Fonagy et al., 1993; Crittenden, 1998.) In processes of reproducing an adult relationship, partners may be searching for a new solution for their insecure attachment by repeating the same kind of patterns they have lived in their childhood (Dallos & Draper, 2005).

Processing the patterns, themes and roles of the primary family of parents not only supports the evaluation of the parenthood, but it also helps the parent to get sufficient distance in their present relationships. That helps parents to change their role in the transmission of anxiety over the generations. (Brown, 1999, p. 97; Kerr & Bowen, 1988.)

It could be considered that this mother's reflective function recovered through processing her own needs and emotions in the music therapy process. The mother processed her own growth through her position in her family and relationship. She had felt herself inhibited from expressing her deepest feelings and divergent opinions in her present relationship, but during the process she started to get the courage to express herself more fully. She begun to reflect her passiveness due to extreme losses and sorrow, and the consequences it had produced in her relationship with her husband.

She begun to see connections between her behavior, state of mind and her relationship with her husband and began to comprehend the occasional anger and irritation of her husband also from a different perspective:

> *M:"… it feels like I have been so passive… it may have annoyed him unconsciously.."*

6.3.4 Family Roles

One of the major issues discussed in her music therapy was her ability to take space in her relationship and recognizing how sometimes the roles in families may *polarize* so, that neither the mother nor the father can be themselves entirely. She could see her husband being responsible for his invalidating behavior:

M:" (his behavior) has kind of got worse with time…although our girl has joined us together, her birth has only worsened his behavior… maybe too much responsibility… but how did he start to behave like that… he hadn't behaved so badly before…it started at the same time as my numbness started to…"

By identifying and expressing her own emotions she begun to recognize the impact that her state of mind had on their relationship. She began to see the polarization of the behaviors in her relationship with her husband, when she was depressed and passive and her husband had to adopt the role of the one who was "strong" and "capable" in their relationship.

Koponen (2010, p.123) describes the change and the distortion of the interaction and the relationship when either one of the partners is depressed. She explains how partners tend to suffer from *narrow and heavy polarized roles of activity or passivity* in depressed families. Both partners loose a part of themselves and some issues become hard to process because of the fear of hurting the depressed partner. The partner who is not suffering from depression may have to *act to be more brisk to protect the children from suffering*. This makes the situation worse as the partner not suffering from depression is in danger of tiring him/herself out and in some cases this leads into a situation where exhaustion grows to a threat of aggression. (Koponen, 2010.)

Koponen (2010) points out, that couple- or family therapies, which offer an opportunity for the client to accept and express his/her feelings, seem to be the most effective. If depression is considered to have roots in the incomplete individuation- and separation development, it is obvious that processing the client's own needs, opinions, emotions and attitudes treat the weak ego. Therapies also seem to be successful when they support the client to see interactions from a diverse position to reflect more deeply the partner's insight and emotions.

Although this mother seemed to be depressed due to the traumatic accumulation of losses in her closest family, she seemed to benefit from processing, expressing and structuring her needs and emotions in music therapy. She begun to reflect her own influence in her husband's behavior and feelings and see the situation as a result of diverse factors in their relationship and family situation. The depression diminished and she begun to see possibilities in her future. She also begun to integrate her past into the situation of her relationship with her husband.

The mother described her experiences relating to her father in her primary family:

M:"...My father was working more…in the country side… he was undeniably a lot there…he was the one in our family who has the last word…that is something I remember… that almost every evening I laid on the floor, my feet on his lap and he was kneading the soles of my feet... it was kind of our mutual shared thing…He was encouraging… that everything goes very well…He was never blaming.. no yelling…"

M: "..My mother was more kind of present…"

Along with the process of her grief and losses, this mother seemed to conceive how the way that her parents had been acting could be seen in how she had learnt to survive emotionally in her primary family.

6.3.5 Moments of Joy

During her twelfth music therapy session, the mother told about her recent experiences:

M: "… I'm going forward and then I am coming backwards… moments of joy and also sadness… it came suddenly, that feeling, that I'm perhaps a bit stronger... and I can. ..those things I feel are important to me… to stick out for them… I'm able to express my opinion on things…if I feel I don't want to go somewhere, I don't have to…for others' sake only… it feels good to decide myself and not only to think about others' opinions…."

The improvisation had changed, the therapist described in her notes:

"… the lightness and finality can be heard in her improvisation…"

The mother illustrated her emotions and thoughts after that improvisation:

M:"…I have woken up to realize, that my own voice has to be heard, too… to have time for me … I would like to go to some dancing lessons in the autumn…African dance of Latino… to get that one hour a week…I've had this idea just now…"

She had grown up to appreciate her own *interests, opinions and needs*. The therapist was defining her progress in the process:

T:"… What you were implying was sometimes very different from the feelings that were emerging when you played…you can't kind of please or lie with music.."

M:"…Yes, it started to appeal to me… that magic.."

6.3.6 Therapeutic Letter and Music

Using a therapeutic letter as a cognitive and experiential technique for therapeutic purposes has been a widely accepted strategy in different psychotherapeutic approaches. It is especially useful for working with deep emotional issues, childhood relationships and difficult feelings. Processing deeply these issues, may increase the client's ability to regulate emotions and also to get release and freedom from anxiety including painful emotions.

The therapeutic letter offers an opportunity to express emotions, needs and anxieties which are addressed to important persons from the client's life in the present and the past. The therapeutic letter is not supposed to be sent forward, but it offers an opportunity to express important issues to the inner representation of important people in the client's life and support the client in processing her/his own schemas and emotions inside. (Prascol, Diveky, Mozny & Sigmundova, 2009.)

Hägglund (1991, p. 100) describes how creativity may be a strategy for connection contrary to loneliness and how it can offer relief for the anxiety of separation.

The therapeutic letter may serve as a support for the normal internalization process of the lost loved one. According to Abraham (1927) this kind of successful mourning is dependent on the amount of hostility towards the one who has passed away. If the mourner is not able to direct the criticism or anger that belongs to the lost one, but attacking him/herself instead, there is a possibility that the mourner shall begin to suffer from melancholia (Freud, 1917).

This mother expressed hardly any criticism towards her mother. She could remember her being absent in her childhood, but didn't seem to experience anxiety or anger because of it. She could discover some negative qualities of her father, but basically she described her parents and primary family quite positively. It may be speculated if she actually had directed the criticism towards herself and suffered from melancholy and pathological mourning, but the loss of the close family members in a short period offers a possibility for an interpretation of normal anxiety and mourning.

According to Hägglund (1991, p. 33), the processing of death is highly influenced by the success of processing the separation anxiety in the early childhood. Managing with the feelings concerning separation anxiety and death demands working with these issues through life, - and this work is most intense during the years in the middle of human life. Separation anxiety is a normal phase in the infant's development from about six to ten months' old and it usually occurs around nine months when a child begins to understand her/his separateness of the mother and experiences fear and anxiety when separated from the primary caregiver. Bowlby (1973) describes how confidence of caregivers availability supports the infant's ability to bear separation. Although fear and anxiety are normal reactions to the loss of a meaningful object, it has been observed, that insecurely attached infants suffer more separation anxiety and have more symptoms of intense or chronic fear than securely attached.

The pattern of the internalized object may be repeated in adulthood, especially when dealing with the death of someone significant. These patterns also influence the way we cope with the emotions raised by the loss and how intense the separation anxiety is. (Bowlby, 1973.) It can be polemized that there were there some connections between the intense and paralyzing influence of the grief due to the death of the (grand)mother and the activation of memories of absent motherhood in the mother's own childhood. The death of a grandmother is obviously not a desirable occasion, - particularly in a situation, where the mother's own childhood memories of an absent mother are occurring because of the developmental probability of them arising in the context of a newborn baby-life and a new motherhood. (Stern, 1998.)

As Goldberg et al. (2000) summarizes, Bowlby considers overgratificating the infant a sign of the mother's maternal pseudo-affection and overcompensation for unconscious hostility. He considers the infant's protest for separation normal developmental behavior which finally results in increased self-reliance. If separation anxiety seems to be extremely low, Bowlby (1959) doesn't consider it developmentally normal, but as an indication of pseudo-independence as a part of defensive processes.

Strong experiences of loss raise very infantile emotions even in adulthood. If an infant experiences a threat to his/her psychic survival as the loss of her/his meaningful object, it creates a feeling of *annihilation anxiety*; a feeling of total destruction, not existing and breaking down to pieces (Freud, 1926). According to Winnicott (1974) an infant needs the feeling of continuity of existing to avoid the annihilation anxiety. This mother expressed a fragile longing and sorrow in her improvisations and in processing the therapeutic letter to her mother. She processed her sorrow and loss very

intensively. The mother's ability to be in contact with deep emotions of sadness and mourning was touching in its sincerity.

According to Hägglund (1991) psychoanalytic theorists have studied differences between feminine and masculine creativity and expression. This mother described diversely her images of comforting, touching and caring. Although these are general images of motherhood, they may be seen as typically feminine ways of creativity. Hägglund (1991) describes feminine fantasies and expressions of creativity which are usually mainly connected with individual emotional aspects. Feminine creativity, expressions and images are commonly related to with nurturing, development and growth. Hägglund (1991) explains how women have close relationship to pain due to sexual experiences and motherhood and they are able to process, ease pain and experience it important and considerable without masochism. It has even been suggested that women may have the ability to process sorrow more deeply because the pain caused by it is not insignificant for the feminine insight. (Hägglund, 1991, pp. 58-62.)

The mother seemed to be in touch with her grief. The therapeutic letter can be seen as "hypermembering", - as Tammy Clewell (2004) describes Freud's (1917) concept i.e. a strategy to "resuscitate the existence of the lost other in the space of the psyche replacing an actual absence with an imaginary presence" (Clewell 2004, p. 44).

The musical interventions, - including the technique of the therapeutic letter, brought the images of the lost one nearer and made the reminiscing more vivid and more emotional (Ahonen-Eerikäinen, 2007; Bruscia, 1998). This powerful strategy asks for motivation and courage. Music represents a transference object of the lost mother, the different sides of her and the relationship between the mother and the grandmother (Ahonen-Eerikäinen, 2007). Klemelä (2012, p. 99) emphasizes, that when the transference experience is maximized in the therapy process, it is important to dwell on oppressive emotional experiences and process them by feeling, experiencing and interpreting them long enough.

This magical restoration of the lost one "enabled the mourner to assess the value of the relationship and" deeply "comprehend what she had lost" (Clewell, 2004, p. 44). By comparing the memories with the actual reality in presence, the client was supported to come to an objective conclusion that the lost loved one does not exist anymore. The grief work supported the mother to release herself from overwhelming mourning and face the loss. This was a focused goal of the music therapy

process with this mourning mother; to support her to integrate the loved parts the people she had lost to her presence and behavior, yet to have the courage to let them go and to move on with her life.

The mother verbalized her images of her father's assumed support in her grief as follows:

> *".. To find strength to go forward… I know that my father would hope that I will go on and not stay where I am and worry… doing things… start and fall into doing…every day it feels that I got kind of more strength.."*

It was important to relieve her of her mourning and to integrate the comforting and sensitive sides of her dead mother for her infant's use. It was also essential to free her from her projections and the influence of her transferential needs towards her infant to get the interaction between them more adequate.

6.3.7 Diminishing of the Projection

In the last third of the process the mother worked on her longing for her dead mother and her needs of comfort and containing. According to Freud (1917), it is necessary to create identification to the lost object to move forward from the sorrow and to contain the connection to the lost one. As Klein (1935) explained, when an important external object is lost, the therapeutic process of mourning needs to maintain or create an attachment to the internal object, in order for the patterning of the internal object to remain the same. (Fiorini et al., 2009.)

According to Robertson & Bowlby (1952) there are three phases describing the loss of self or of objects:

1. protest
2. disorganization
3. restructuring

It seemed that this mother was simultaneously in different phases of loss. She had lost her mother a few years ago and her father had died just recently. She was still in a disorganized state with "despair, depression, withdrawal, social isolation and slowing down on physical activities", due to the loss of her father. She was still looking for marks of her father's presence in their summer cottage, desperately and uncontrollably crying when remembering her father's marks there.

At the same time she seemed like being able to move on to a restructuring state of processing her mother's meaning and integrating her qualities to her present with her daughter.

In the music therapy this mother was able to concentrate on her "work of mourning" (Freud, 1917) by expressing her despair, yearning and longing for consolation with musical improvisation. She had an opportunity to have her despair contained musically and by discussion in music therapy. The letter to her mother brought out the longed-for traits and properties of her departed mother. By recalling appreciated qualities of her mother, - also in the context of her grandparents' care and love, she was supported to integrate them to her own traits of maternity in herself.

Music acted as a cradle for creativity, play and new potential. It created a potential transitional space, where the mother was able to process her sorrow and longing to be nurtured by her own mother. (Klemelä, 2012.) With the support of the music therapist she could process her mourning and identify to her mother's sensitive and comforting sides (Hägglund, 1991, p. 245). Transferring these emotions into a musical output and expression and processing them in a therapeutic relationship supported the mother to move her mother-transference and projected anxiety from her infant and helped her to bear and contain her own sorrow and needs of getting comforted (Winnicott, 1971).

The mother had paper and pencils in front of her on the floor and the music therapist's instruction for creating the letter was:

> *T:"What would you want to say to your mother, what would you want to tell her, according to you and your daughter… How would your mother hold your daughter? How would she react to her? What would you want to tell about your daughter to your mother? If you want to stop in the middle of the process, it is ok to stop. Or if it feels too heavy, you can say it to me, so we can change the task or stop and deal with the things that arise now…"*

The *music* used was chosen on purpose to be quite melancholy but supportive from the emotional content of it. The Ravel's concerto used at the beginning also has some disharmonious characteristics to create mild tensions to process potential negative contents of the mother's relationship with her mother or with the death of the grandmother. Part of the music chosen, - i.e. the concertos of Bach, were structured and had a quite clear rhythm and form to maintain the mother's psychic state steady enough. The music of Shostakovich was chosen because of its melancholic sensibility and strong holding atmosphere. The music used in this task was the following:

- Ravel, Maurice: Piano concerto G major. Second movement.
- Bach, Johann Sebastian: Concerto for 2 Violins, Strings and Continuo in D Minor, BWV 1043. Second movement.
- Bach, Johann Sebastian: Concerto for Violin and Oboe in C minor, BWV 1060R. Second movement.
- Shostakovich, Dmitri: Piano Concerto No. 2 in F major, Op. 102. Second movement.

The mother cried, wrote, brushed away her tears, wrote again, snuffled, and created a letter to her dead mother, the content of which is reproduced below:

"My dear, dear Mother of mine, I'm now writing you the letter, which I never wrote to you when you still were here with me…I want to thank you for the fact that it was you who was my mother….I experienced that kind of love and acceptance which I will never expect to get from others anymore.

I could feel being good and needed as the person I was… You gave me thanks and praised the things I did. You nurtured and cherished me with the world's softest and loveliest hands. No other touch is as sensitive as your hands' gentle caressing… You set the example of always supporting the weak… I understood that all kind of life is valuable…human beings, animals, nature…

You gave so much support to the others that you forgot yourself a bit too much…You were the aggregating force that we have missed here...Not because you would have wanted to make yourself important, but because it was so easy for everyone to come to you…

It is a wonderful day in the early summer, the kind you loved…light, greenness and aromas… I miss you so much… I hope you could be here with us… with me and your little granddaughter… you know that you would have been so happy for her! Nurtured her as you once nurtured me…

But at the same time you would have nurtured me when I am sometimes so down. Maybe with your support I would have coped better…Anyway, I want to believe that you walk with us there somewhere… and here in our hearts. I believe that your strength is passing through me to my daughter...as grandmother's strength passed through you to me… We are one continuum which passes from mother to daughter and that is that kind of altruistic love, which you can't compare with anything...

Thank you for getting this experience of the greatest love from you, precisely. It is the strength of my life, by which I'm able to support my daughter, too..

With love and endlessly missing You…"

This letter interrelated the contents of the mother's improvisation and their verbalizations and helped her to integrate her *experience of motherhood and nurture across generations* into her own family. She talked about her mother's hands and touch, the same way as she had described her experiences in her first improvisations with djembe- drum in the beginning of the process. It seemed remarkably important that she had the possibility to process her grief and longing for the perfect and all-embracing love from her childhood. Retrospection to her own early experiences of her mother supported her to take hold of her own motherhood and to connect with her own daughter.

6.3.8 Negative Memories from the Primary Family

The mother didn't reach any contradictory early emotions from her primary family in this task. In the end of the session she nevertheless approached memories with negative contents of family history:

M:"A while ago I realized that my mother's father was not…. so nice to my mother… but her mother's mother was... so she got that love from her mother… yes… it came somehow also from grandmothers… that kind of women's continuum…"

In the fourteenth session the mother processed the difference between affection and restriction:

T:"I kind of like that you are stroked or patted… I try to show her that she is important for me…"

Although this was a beautiful concept, it was obvious, that children need their other needs to be met, too. In this case it was not about the need for affection. When the child was angry or frustrated, it seemed important not only to recognize some infant's need and respond to the infant in adequate timing, but also to offer an adequate interpretation of the message of infant's expression. The goal of being able to distinguish between the different needs of the infant proved to be essential and was

worked on thoroughly in the last third. The mother's expression revealed that it was challenging for her to separate her own needs from those of her infant:

M:"One thing I have thought is that there isn't so much hugging from my daughter..."
T:"Can you remember that you would have gone as a child and just hugged your mother…?"
M: "(starts to cry and nods)… somehow I remember that… that warmth…and.,."

The mother understood the meaning of responding to some of the infant's other needs:

M:"The bedtime is such a big hassle…back and forth…when you take her there, that you have to lay down now… sometimes she needs to be told that…"
T:"Children like beginnings and endings… the experience of that something is important to adults…. you can sometimes even exaggerate to make things look very significant..."

The mother brought up her joy of progress during the music therapy process.

M:"The masturbation, it has almost disappeared… it felt so good, when we played the musical dancing-play.."
T:"Didn't it! It was kind of a victory when she didn't start to masturbate as a result of that jumping… and she was laughing."
M:"Only that kind of funny jumping… in the beginning there was that masturbation ..."

The girl was beginning to choose interaction instead of masturbation in the situations which had caused insecurity previously.

The improvisation at the end of the fourteenth music therapy session was rhythmic and strong. The mother *looked determined, self-confident and aware of her own authority on the basis of her musical expression.* She moved her head from side to side charmingly. She slowed down her improvisation laughing:

M:"Anyway I felt like going on somehow… it (music)takes me with it… sometimes I feel so sad because I always miss things so much…but somehow I also get rid of the feeling… I'm able to... it is not on all the time… like here now, this moment was just so nice that it was just wonderful… it has been such a mood raising experience…It is so nice, that although I never have played any instrument, everything has just been an experiment and it is so kind

of terribly fun! I have thought a little… that I could someday maybe write to my mother… I have always liked writing… it is more special to me than speaking... through that my girl could get something important from me…"

In the last music therapy session of the mother, she described her feelings about the ending of the process:

M:"On the other hand I am kind of afraid because this has... been terribly important at least for me… I suppose I have got some kind of support and let my thoughts out… it feels that my girl now responds differently… she is searching for more contact with me… "

"It (sadness) emerges from little issues… it takes a while and then it disappears... almost every day... it doesn't stay like it would be all the time that grief…I'm able to give space for joy, too…

The music therapist was gathering the achievements of the process and specifying the goals which were still open:

T:"You have brought your sorrow and many memories of your important departed family members…good things and contradictory things…

You have told about your relationship with your husband and problems with that…You have improvised and reached different sides of you… you have been able to release your feelings of sadness and anxiety... give names to them and a channel…it can be seen as a strengthening in you… liveliness and assertiveness have emerged..

You have had hard times and your girl didn't want to see your sorrow in your eyes… it takes time for her to revive her confidence in your presence…But something we perhaps didn't process much are your feelings of anger… it is so challenging for you to fight back…

Anger is a healthy feeling, you brought up that your girl has caused you that kind of anger which you have never experienced before … those feelings we didn't handle much …Feeling is never bad, because it is different thing than doing bad things…"

M:" I remember when she was only a few weeks old... my husband had left to work... it was a beautiful weather and I thought that now we would get out...and then this terrible crying started… I was so angry that I hit the floor with my fist... that we can't go out yet again! That left me with such a bad feeling… when I kind of hit that floor…"

T:"But mothers do hit the pillows, shout at the pillow… that's the way they react when they lose their basic rights…it is really tough... especially when you don't have that community there: grandmothers and aunts…But to have a guilty conscience… you didn't do anything that would really have hurt her..."

The music therapist continued by giving concrete alternatives for how to deal with challenging situations when the baby continues crying regardless of the efforts the mother may have taken to help her. It seemed challenging to help the mother to bear the feelings of guilt when illustrating the situation which had led to the infant's rejection. The music therapist was describing the difficulties of families who have a baby with infantile colic and tried to make feelings of frustration, anger and surrendering seem natural in that situation. The mother described her feelings:

M:"The mother doesn't know what to do…. The mother can't help you now…My daughter has heard me saying that for so many times… when I have been completely desperate..."

It turned out to be essential to help the mother to diminish her feelings of guilt. That supported her to communicate with her infant in present and not as a reaction to previous problems or mistakes which had made her infant only more confused and frustrated.

The grief of loss and the longing were still nearby. The mother illustrated her inability to sing to her child:

M:"Singing makes me think that… it would be nice to sing to her in the evening…I haven't been able to sing any lullabies… the songs that are linked at sleeping I have left completely…haven't had the courage to sing then…

T: "Do you become sad?"

M: "Yes… But she likes rhyme books very much…."

The therapist gave positive feedback to the mother for having the courage to discuss her feelings of shame linked to her infant's masturbation symptom. Unconscious painful feelings may create extra pressure and contradictions to interaction and lead to perverted ways of reacting to an infant's emotions and initiatives.

The mother was supported to encounter her feelings at other levels, too. During the process, it had become obvious that she had challenges to express her anger and frustration intensively:

M:"We were talking with my husband… I was annoyed of something and he said, that he just yelled it to me! We have such a different way of expressing ourselves… I suppose he is irritated sometimes that I can't say it out loud….He roars and I get smaller and smaller…I have a habit of reacting like that …"

T:"Your thoughts and feelings don't hurt anyone… if you recognize them and understand that you also have the right to get angry… to show where your limits are…And the anger can be sensed anyway in the atmosphere… It pops up in some other way anyway then…You should have this permission of being that lion mother…"

In the last improvisation the music therapist instructed the mother to express those feelings of annoy and anger by playing:

T:"Do you think it would be ok to search for those loud nuances… how would it sound if you said something loud, if you would say it loudly? How strongly could you say it?"

The mother found the *instruction very funny, she laughed* and started to play the djembe drum. She played quite softly, the music therapist was provoking her a bit to assume louder dynamics but it took a while before she started to play more intensively. When reaching the loud and hard dynamics by her playing, the mother started to laugh tremendously and continued playing with intensity.

After the improvisation she illustrated her feelings:

M: "Somehow it takes away my strength… it really makes me tremble… it resists me.. I've got that kind of feeling that: Obey me! But it doesn't… It is so physical, I feel that I am not allowed to do it…"

T: "But you are allowed to say… You have the permission to be angry and say things assertively… Like: Stop it! Or: Obey me now! Everybody has those kinds of feelings…"

M: "Those days with my daughter… it feels I'm not allowed to say things assertively…Yes… Like at the bedtime when I sometimes say like: "Now!", then she finally understands that…"

T:"It is important for an infant that the mother has views or opinions of situations…it also prevents depression... it's important to feel that some things are important, not objective truths, but meaningful…(shows loud expression with the drum) You can use this feeling for limiting and protecting your child and yourself…"

The music therapist gave examples of anger and rage for making them more normal and allowable for the mother:

> *T: "You can't avoid the rage when your girl is about three….they are raging all the time (the mother is laughing aloud)…. You can give alternatives to her but you can't be afraid of the infant's rage… and you have to be able to protect her from dangers…and to be loyal to her. If you have forbid her from doing something, you not change your mind but help her to bear that feeling of rage…*
>
> *When you are connected to your feelings of anger, you don't necessarily have to even yell, you are able to be convincing enough anyway…"*

This explanation aims at giving the mother the permission to express her feelings of anger by making them natural and useful for herself and her child. With the improvisation she was able to approach her denied feelings and to have a contact with an opportunity to express them. In this clarification, the music therapist integrates this new, emerging feeling to the normal human childhood developmental phases, - including the mother's own development. The discussions and the improvisation gave the mother the opportunity to understand and bare the emotions of her infant after being able to identify, express and gradually regulate those feelings in herself.

The music therapist ended the session by summarizing the mother's strengths:

> *T:"You have this strong side of being available for your infant. You are an open and honest person, and you are emotionally alive… You have committed to your child and you love her… We have dealt with sorrow, shame, your primary family… and now this aggression, too… You can work on those things… that you have a permission...You have worked so well…"*

The mother cried and hugged the music therapist strongly for a long time:

> *M: "Thank you so much... (cries)"*

6.3.9 Gratitude

Mahler et al. (1975, pp. 42-43) have considered an infant's first few weeks a state of *normal autism* wherein the infant is in a fetal reminiscent state of primary autonomy without an awareness of a mothering agent prevailing. According to Winnicott (1971) infants do not experience a world outside separate from their magic omnipontent control and regulation. Stern (1985, p. 39) instead argues that - already during the first weeks the infant is taking in external events and regularly occupying a state of alert inactivity (Wolff, 1966). Present investigations assume that the infant is more active and aware of the closest environment and important objects, but still dependent and incapable of limiting the influence of too stressful or traumatic events on his/her developmental phase (Stern 1995, Sinkkonen, 2001).

According to Klein (1957) *gratitude* is dependent on the ability to trust in a good object. Separateness of the mother and individuation process are not successfully overcome if the internalization of a "good enough" mother is not requisitely strong (Mahler, 1975; Klein, 1957; Winnicott, 1953). The feeling of gratitude is not possible without recent individuation and understanding of the separateness and the border of the "other" and "self". Gratitude is a feeling that joins the bad and the good as a whole without a split. Good object becomes assimilated and the client's ego is able to experience love in addition to containing and managing the conflicting feelings towards the object (Klein, 1957). Klein (1957) sees gratitude as a "goal of a psychoanalytic process" (Hiles, 2007).

7. RESULTS

This research was executed to discover the connections between the mother's own music therapy and the mother-infant music therapy process. The influence of music therapy processes on early interaction was also investigated by a Care Index- assessment with both parents. It was necessary for illustrating the impact of both parents on the cooperativeness of the infant. In addition, this study gave information of the importance of choosing an appropriate focus in the early interaction music therapy according to the mother's present life situation.

7.1 Overview of the Care Index Assessment Results

The Care Index assessment overview was done by Airi Hautamäki, professor of social psychology and psychology in the Swedish School of Social Science in University of Helsinki. In the pre-process assessment video, she interpreted the mother as a depressed woman, who could not catch the attention of the infant. She assessed the mother as a low-key person, unresponsive to the infant. She assessed the infant as passively resisting or passive. Professor Hautamäki assumed on the basis of the videos that this mother was willing to seem to be as good a mother as possible and she assumed that it was probable that the infant had learned to deal with the anger of the mother in a passive way which had then been confirmed by the mother.

Prof. Hautamäki (2013) did not see any marks of joy in the infant and no shared joy either. The sensitivity of the mother was scored at about four points, - which is classified as a parenthood *"at risk"* according to the Care Index scoring (Crittenden, 2006). Interaction under four points is usually seen as requiring the establishment of a child custody customership in early interaction treatments. The remaining scores Professor Hautamäki interpreted as unresponsive-active, especially in the

emotional side, with few small efforts of control. She saw almost no reciprocal acts between the mother and the infant.

Professor Hautamäki's recommendation was to process with the mother her inner experiences of the infant and her expectations towards the infant and to investigate why this mother felt- as was supposed - that the situation was so difficult.

In the post-assessment video Professor Hautamäki interpreted this mother as "acting as a good mother", the infant not sharing the mother's emotions. The mother seemed to react adequately to the infant's signals, she noticed them and she reacted to them. She assumed, that it was challenging for the infant to understand to what she should react: to the mother's genuine emotions or to the over tuned and acted behavior which the infant was receiving from her. Professor Hautamäki assessed a significant increase in the controlling behavior in the mother but saw the synchronization to the infant as weak as before. Professor assumed that this mother was trying to imitate the therapist and act as a good mother, but showed very little reciprocity or shared joy. Instead of showing her melancholy, the mother had developed an A-type *false positive affect* (DMM-circle on page 9) which may lead to compulsiveness of the infant. Professor Hautamäki assumed that if this mother returns gradually to her melancholy state of mind at home, this infant will continue the passive-aggressive line.

She assessed the infant as C-type, *ambivalent-resistant* (DMM-circle on page 9) if this resisting behavior is a sign of trying to get the mother's attention. If this behavior scored as *"difficult"* is keeping the mother "going", it may be a sign of a developing *compulsive caregiving* (A 3-4 in DMM-circle on page 9). Otherwise there are no compulsive signs observed, in spite of a couple "sqeezed" sounds. The infant is resisting and rejecting to the mother's initiatives. Professor Hautamäki saw almost no long reciprocal acts between the mother and the infant. The synchrony stayed low. The sensitivity of the mother was on the area labeled *"inept"*-area, scored at 5-6 point.

The interaction with the father was more genuine and reciprocal, at the level of "*adequate"* sensitivity with about seven points in the Care Index scores. She described the father as more present in his interaction and not trying to be anything else than he is. The infant was reacting to this positively and reciprocally. Professor Hautamäki considered that the aims of the mother in the future should be "processing her feelings and specially the ambivalence of them". (Hautamäki, 2013.)

7.1.1 Reflections of the Assessment

The interaction with the father was assessed only once. It didn't give information about the development of the interaction in the music therapy process, but it pointed out the differences between the mother's and father's interaction with the infant. It helped the therapist to understand the interaction of the infant in its entirety. The mother's sensitivity assessment scores in the range of *"inept"* –area, which could have required a more intensive and long-lasting intervention of open welfare early interaction treatment, but the contact and sensitivity of the father protected the infant from major risks in the child welfare context.

The main results of this assessment were very similar to the interpretations of the music therapist in the process. The recommendations of Professor Hautamäki concerning the goals of the treatment, mainly related to the issues that were processed in the mother's own music therapy. The deeper insight as to the ambivalence in the mother's feelings was not entirely achieved in this short process of early interaction music therapy and the mother's own therapy.

In child welfare, there is a pressure for an urgent recognition of the needs of the infant in order to avoid the worsening of the infant's state and more serious influences on the infant's developmental prerequisities. The work with the mother may involve controlling aspects due to the urgent needs of the infant. This evokes sometimes stress and a passing tendency of imitating the therapist without actual emotional content of the behavior. This is a commonly known phenomenon among professionals in the area of early interaction treatments.

Occasionally happens, that early interaction plays evoke connection between the mother and infant in addition to the increased understanding of the interactional dynamics for this specific infant's needs. Also the mother's playfulness may increase along with her courage. This may proceed to mutual joy and a cumulative understanding of the needs of the infant. Sometimes it also happens that the mother is imitating the therapist with her acts with the infant and the emotional capacity can only be evoked by offering the mother her own therapy process, in this case with music therapy.

The major breakthrough of the projections and the ambivalence behind the mother's behavior towards her infant didn't show until the last phases of the music therapy and early interaction assessment process. In the post-assessment situation of Care Index videotaping at the family home,

there was a breakthrough with the music therapist in her realization of the inhibiting factor constantly present in the mother's interaction with the infant. In a video assessment situation, the mother's tendency of not continuing the initiatives of the infant was clearly present. She responded to the infant's initiatives obediently in accordance with the music therapist's guidance but in practice she broke the continuum of the reciprocity by moving the object to an inaccessible place for further play. At the post-meeting after the process, the music therapist interpreted to the mother her tiredness and sorrow as an influencing factor behind her unwillingness to continue the initiatives of the infant. Unfortunately, this breaking of the continua and the emotions behind it were revealed in post-assessment, which is why it was not investigated during the music therapy process.

The mother's well-meaning intentions made it challenging for the music therapist to uncover the reasons behind the strong resistance of the infant in their interaction. This generated strong *counter transference feelings* of sadness, compassion and confusion in the music therapist. The denial of the continua of reciprocity arose from the inner and supposedly unconscious tendency of the mother. It was presumable that she was not able or willing to continue her interaction with the infant in an interaction situation. That was probably obvious to the infant who has a major capacity to interpret the information of non-verbal acts and behavior of adults (Barral 2009, Dolto, 1984).

The concept of *unresponsive-active* way of interaction refers to an interaction behavior where the mother is occupied by an inner activity, i.e, - a traumatic, psychotic or other similar issue, and she is experienced as passive due to her minimal genuine presence in the infant's initiatives, contact and communication. This mother was occupied by her mourning, and her longing and needs of being comforted and nurtured.

This resulted in a painful interaction where the mother was trying to respond to the initiatives of the infant but was covertly inclined to express her longing for being by herself, - perhaps not taking care of anyone, but being comforted in her own loss and sorrow. The infant was rejecting the presence of the mother due to her presumably quite precise interpretation of the mother's unwillingness to be in contact due to her own neediness. The mother carried her sorrow in her behavior and acts and the infant was not either willing or capable of joining that.

7.2 Mother's Experiences of Sorrow and Recovering

According to the clinical observations, this mother was extremely sad and melancholy in the beginning of the process. The discussions and improvisations with the mother pointed to six main categories: grief, loneliness, longing, the inability to stand for her own rights, the uncertainty of motherhood, worries and shame about the infant's masturbation symptom. In the beginning of the process, her improvisation was quiet, soft and not structured. She cried many times during the improvisation and discussions and could not show any signs of joy or happiness when she was interacting with her daughter. The behavior of the mother was from the beginning comfort and support seeking. It was evidenced by notable amount of hugging, crying and eye contact with the music therapist.

The mother worked on her feelings towards her infant and she especially processed her loss and grief due to the loss of family members and as a result was able to make more space for understanding her infant's real needs instead of focusing in her own neediness. It seemed that although the mother felt worry and shame about the infant's masturbation symptom, it was easily observed in the interaction situations that she was constantly working on these emotions in order for not to show her doubts to the infant. The uncertainty of the mother was not surprising, considering that she was a woman in more mature age for a first baby, she had had these great losses just before the infant was born and the infant had quite severe symptoms which were also socially confusing.

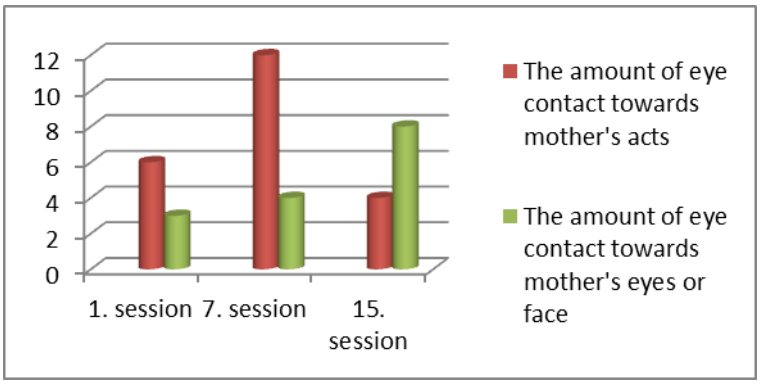
During the process, - in the second third, she begun to play more rhythmically, having airy improvisations, with a smile in her face. She could experience joy when playing with her daughter and laughed, not often, but occasionally when fooling around with musical plays.

She begun to look into the future: she imagined how she would like to take dancing lessons, started to have dreams of new studies or a new profession. She begun to take her place in her family system and had more courage to express her negative feelings and opinions also at home. From the development of the improvisation it was possible to interpret that the mother's expression was stronger and more organized in the end of the process. Together with the verbal outcome, it could have been interpreted as a diminution of the depressive emotions of the mother.

7.3 The Amount of the Infant's Eye - and Face Contact

The positive expectations of the infant towards the mother seemed to increase along with the recovering and increasing initiatives of the mother. Along with the increased amount of the eye – and face contact during the process the infant started to show more interest towards the initiatives and contact of her mother.

The amount of the infant's eye contacts towards the mother was analyzed three times, four minutes from the beginning, in the middle and at the end of the process. The contacts were investigated in the improvisation-mirroring part of the session of the mother-infant-music therapist triad. The initiatives were divided into two categories: initiatives towards the mother's actions and direct contact with the mother's eyes or face. It is worth noting that the number of eye contacts was considerably lower in the beginning of the process. The number of eye contacts towards the mother's actions was in the beginning smaller, while in the middle of the process it was at its highest level until it diminished when actual eye/face contact was increasing. It was unquestionably evident that the number of eye initiatives of the infant was dramatically increasing towards the end of the music therapy process. The infant's interest in the mother's acts was preceding the actual face and eye contact.



An interesting observation was that the infant's interest in the mother's acts increased before she started making more eye/face contact. It implicates that it was possible that the infant was reassuring itself of the initiatives from the mother before she begun to make contact with mother's eyes and face. This mother had been insecure and remarkably sad for the first months of the infant's life. The

amodal perception and psychic development of the infant (Stern, 1985) prevents the infant from setting limits for the overwhelming emotions of other people from his/her environment. It could be asked if it would be possible to interpret that the mutual acting and mirroring in musical world in music therapy would have been a kind of condensed early interaction where the mother had the opportunity to inform her infant of her new and different emotions and acts which were easier to internalize and more receivable for the infant.

7.4 The Diminution and Cessation of Masturbation

By analyzing the video it could be observed, that the infant's masturbation was radically diminishing and finally stopping entirely during the music therapy sessions. According to the mother's description, masturbation was also diminishing significantly elsewhere. Within the music therapy process, a slight increase of the masturbation was observed just before it finally disappeared.

The increase of the masturbation before its disappearance can be explored from different perspectives. It was not clear what kind of changes there were in the family atmosphere before the increase of the masturbation. It was not possible to make definite conclusions about *the influence of the family circumstances* on the infant's behavior.

According to Uhinki (2012, p. 365) in psychotherapy processes, clients' experience an increased manifestation of their symptoms before they finally disappear. The appearance of the symptom may also be connected to the mother's potential psychic absence or distance as her own therapy process was ending simultaneously. The disappearance of the symptom in this music therapy process may be interpreted as a sign of the fulfillment of the infant's needs to be mirrored, seen and heard in her interaction with her important objects.

Early interaction music therapy is based on different interaction sequences with music or play. The interaction sequences may be repeated and the therapist is creating "*mutual emotional memory representations*" based on the contents of the sessions. These are kind of *functional, shared memories,* which strengthen the infant's experience of safety, predictability of life and trust for contact. This predictability, contact and trust may have been part of the reasons why the masturbation symptom became unnecessary during the music therapy process.

According to the observations of the music therapist, the most important factor was the possibility to mirror the infant musically at the *vitality affect level*. Masturbation disappeared first from the situations where the infant's improvisation was mirrored musically. The amount of masturbation decreased to concern only few situations during the whole session, until it was not seen in the music therapy at all. It occurred on specific occasions at home and en route but diminished even there until it stopped entirely. It could be interpreted that masturbation as a compulsive behavior compensating for the lack of mother's contact and for the missing support for emotion regulation, did become unnecessary when it was replaced by an intensive musical and emotional communication and mirroring at the vitality affect level.

8. DISCUSSION

This research originated from the author's clinical experiences of early interaction music therapy in the field of child protection. The hypothesis of this research was, that processing the inner meanings and dynamics of a mother's musical improvisation may inform from her primary family interactions. Working on the psychological content of the primary interaction models may widen the expressive and containing capacity of the mother so, that she is able to mirror the emotional content of her infant's improvisation increasingly.

The mother's encounters with her infant are dependent on her capacity of bearing and containing the expression of her infant. The capacity of containing the infant's emotions is dependent on the mother's own ability to identify her feelings and regulate them. The challenges of regulating and containing various feelings arise from the interaction and attachment models of the mother's own history.

By investigating the background of the dynamics in the mother's improvisation in music therapy, it may be possible to enter into the biased interaction models deriving from the mother's psychical history. Resolving the traumas deriving from the mother's history and the possible delays in her psychical development may give her an access to a wider range of expressive dimensions and help her encounter her infant more completely. This may have influences on her daily interaction with the infant and her ability to contain the infant's emotions and needs more widely.

This research did not support this hypothesis directly, because this mother had current traumatic losses which put an overwhelming burden on her psychic capacity. She was not in a sensitive period for attending her psychohistory according to possible traumatic issues because of the actual pain of the losses in her family. Her period of mourning was the issue processed at the time and she was not pressurized to enter her childhood memories in any other contexts than what was necessary at the time.

The original hypotheses were based on the clinical experience of the author, but were changed during the research process on the basis of the material gained and the ongoing music therapy process. According to the observations, the material gained and its analysis a new hypothesis was set to the future investigations: "Musical improvisation may be efficient in influencing the interaction of the mother and her infant by diminishing the projections towards the infant through processing the mother's inner emotions towards her important objects in the present or in the past."

The purpose of this study was to answer the following question which may deserve more investigation in the future: "Are musical improvisation and the processing and verbalization of emotions efficient tools in releasing the client from projections? Does this processing influence the musical mirroring of and the interaction with the infant?"

This music therapy process turned out to be flawed in terms of the sensitivity of the mother and the interaction between her and the infant. The short duration of the music therapy process presumably influenced the low sensitivity scores of the mother; the major insight of the projected feelings of the mother was discovered only at the end of the process and there was no time left to process that. Also, it is obviously not useful or even possible to try to shorten the time that is demanded for the natural progress of grief processes with any therapeutic intervention.

Although the sensitivity of the mother in her interaction with her infant stayed in the *"inept"* area, many of the working methods used with the mother influenced her symptoms of depression. She begun to describe her life and her future in a more optimistic and productive way and started to take a stand on discussions at home. Her improvisation started to include brighter nuances and lighter rhythmical material. She also verbalized the contents of her improvisation in more forward-looking and hopeful way.

The most essential result of this research derives from investigating the mother's projection of feelings to the infant. The clinical assessment of the Care Index videotaping situation revealed the mother's tendency to stop the continua in the interaction with the infant. She expressed her unwillingness to continue the contact with the baby, presumably unconsciously. The reason for the inability to stay in contact with her infant was revealed in a videotaped situation where she was soothing her baby after preventing her from going to a dangerous position. The mother was calming down the infant as if she had been experiencing a great sorrow of loss, although the infant seemed

rather as if she were furious of the limitation made by the mother. Processing the video with the mother made her recognize that she was offering her infant something else that what she needed. She was offering comfort for a great sorrow and mourning although the infant was not experiencing it. It was the feeling of the mother, which she had *projected* to the infant. She also stayed so long in the comforting situations regardless of the rage of the infant that this suggested that the mother presumably had *transference expectations* relating to the hopes she had of the grandmother comforting the mother herself.

During the music therapy process, the mother investigated emotions, needs and hopes that supported her to *release herself from the projection and transference* towards her infant. Although this clinical observation of her distorted feedback to her infant was made in a latest phase of the music therapy process, the mother had worked on her sorrow during the process from the beginning. Her *improvisations*, expressing the longing for the comfort, touch and the lap of her mother, helped her to feel and process her own feelings. The *letter to the mother* was the culmination in the integration process whereby grandmother's nurture was becoming the mother's own property and that inner strength was being transferred to her infant. By containing the mother's sorrow and mourning, the music therapist gave her the presence of the "absent grandmother" and gave her the comfort that she had projected as her infant's needs. She got the opportunity to identify her considerable need to be consoled by her mother and to release the infant from the projection and from carrying the transference figure of the dead grandmother.

It could be interpreted, that the mother unconsciously informed her infant of her unwillingness to be in contact by stopping the continua in their interaction. The information derived from her acts was more like a request for comfort and love, a manifest of a need to be consoled by her mother and not nurturing her own infant. The infant interpreted the mother's behavior well: she didn't want to look to her mother's pleading or mourning eyes, not to take initiatives, which would be cut off by the mother and not to be in a lap were her genuine feelings were misunderstood.

The mother processed her inability to express anger by improvisation. At the end of the process she had the courage to express loud sounds and to enjoy from drumming loudly. She begun to take her place in her present family and to take on the role of the mother as an important caregiver and to also verbalize her feelings or her anger.

Although this mother processed and reflected her feelings in multiple ways, her sensitivity in the interaction stayed approximately the same throughout the process. This is an indication of the need for longer processes and more time for working with the projections and transference expectations towards the infant. It also informs us of the fact that more time is required in order for the mourning phase to be adequately worked on.

In the early interaction therapy processes, the emotional load is diverse: the *counter transference* feelings concern the mother and the infant. The counter transference feelings of the music therapist were confusion concerning the good will of the mother, her open emotionality and the constant resistance of the infant. The compassion towards the efforts of the mother and the disappointment of failing to get a response from her daughter created an emotional load to the process. The transference expectations of comfort pointed also to the music therapist and made the goals of the mother's own music therapy process clearer. The main counter transference that rose from the infant's experiences was the irritation deriving from offered acts of calming and pity when infant seemed mainly irritated and angry. Creating an understanding and a productive therapeutic process, while taking into account these different perspectives of an emotionally injured mother and infant, remains as an inspiring challenge to every early-interaction therapy process.

This family was not a client in child protection, presumably because of the sensitivity and capability of the father involved. In spite of this, this process may anyway be seen as a case study in a field of child protection family on the basis of the Care Index scores under five points in the beginning, which, according to the professionals in the field, mean a "child protection" limit.

According to the video material and the descriptions of the mother, the music therapy process succeeded in diminishing significantly, i. e. - almost totally, the serious masturbation symptom of the infant. This research considers the masturbation symptom a compulsive stimulation for self-regulation in a situation, where the mother has been emotionally absent in essential phases of development of the infant's basic security. Serious deprivation in the infant's development under five months' age may create the symptom of masturbation (Salo, 2012; Hautamäki, 2012). It was interpreted that this infant created masturbation as a comforting transitional object (Winnicott, 1971) and as a "second skin" (Bick, 1988) which makes the infant more conscious of her/himself when the primary caregiver is not emotionally available enough. The explanation of the disappearance of the masturbation symptom during the music therapy process may be found in the Stern's (1985) concept

of “vitality affects”. They are the basis of infant’s expression and experience of life and interaction and alike of their nature with music in many ways. Offering a musical mirroring instead of compulsive masturbating may respond to the infant’s earliest needs of being in contact with the absent mother. The unfinished developmental phase may be achieved in a musical interaction, including emotional and musical mirroring.

The research showed that the number of the infant’s gaze– and face contacts towards mother increased during the process. According to the results, the infant was first increasing her gaze contact to the mother’s face. It may be interpreted as a sign of interest in and an insurance of the mother’s intentions and perhaps her emotional state of mind. The number of the mother’s initiatives had increased supported by the music therapist and this may have created some kind of expectations of positive involvement of the mother. The amount of the gaze contact toward the mother’s face decreased simultaneously with the increase of the gaze contact to mother’s eyes. The gaze contact during the music therapy sessions was increasing significantly during the process.

Although the hypotheses of the research were not confirmed and the validity of the research was not as desired as far as the first research question was concerned, this research brought up important new material for further investigations and for the clinical practice. As was presumed in the beginning of the research: “Abduction is a suitable framework for this music therapy case-study, because it is grounded on unverifiable assumptions and it reflects and interacts with the empirical perceptions of the data and the theories The clinical experience and knowledge offers the researcher a framework for interpreting and explaining the perceptions in the process, but the interaction with the theories and the data may also create new, surprising facts and definitions”. (Ahonen, 1998; Peirce, 1965.)

Regardless of the unexpected results, this research gave useful information for the field of early interaction and music therapy treatments. According to the author’s clinical observations gained from music therapy within the context of child protection during ten years of professional practice, the limitations of the musical expression of the mother are often related to her psychodynamic history and to the interaction patterns in her primary family (Lipponen, 2008). Certain inhibitions and compulsiveness in the mother’s expression in her improvisation seem to reflect transference expectations and projections. They are more connected to the mother’s inner images of the potential therapy group’s, music therapist’s or imagined listener’s expectations or characteristics. This research

revealed the importance of investigating the mother's present projections towards her infant, including transference expectations.

As professor Hautamäki (2013) described, some early interaction treatments may increase control or pseudo-affect in a depressed, low-key mother and in the worst case, also the compulsiveness of the infant. Especially a depressed, low-key and unresponsive A-type mother may develop a false positive affect in her interaction with the infant by imitating the acts of the therapist without real emotional sensitivity. When implementing this three phased Early Interaction Music Therapy Model during the clinical practice of the author, this phenomenon of increased compulsiveness in the infant due to the mother's false-positive affect during the process has not occurred. This phenomenon may originate from the intensive vitality affect level mirroring, that the infant is receiving in the music therapy regularly in the context of Communication Emphasized Music Therapy.

In this case, - as in many situations in child protection, it was urgent to address the psychological and self-expressive state of the infant in order to prevent more damage from occurring in the infant's psychical progress. Communication Emphasized Music Therapy and musical mirroring of the infant at the vitality affect level has proved to be an effective way to support the infant's self-expression and to induce the infant to contact and communication. Clinical experience has examples – where even the most withdrawn infant in an almost autistic state has started to take contact due to musical mirroring within Communication Emphasized Music Therapy. This effective way of treating the infant proved to be successful also in this research, but guiding the mother to mirror her infant musically proved to create a false positive affect in her interaction and did not increase her sensitivity significantly.

On the basis of the results it could be suggested that depressive of unresponsive A-type mothers does not benefit from guidance in their interaction, but benefit more from their own processing and Wait Watch and Wonder-type (Hautamäki, 2013; Muir et al., 1999) reflection of their infant's behavior. Reflective ability arises as an influential treatment goal with mothers, but the mirroring treatment of the infant is often essential, especially in the context of child protection.

The reflective ability is also increasing also in the mother's own processes, as was the case with this case this mother's own music therapy process. It triggered issues and emotions which were essential for processing the mother's "inner scripts" and unrealistic expectations and conceptions of the infant in order to release the infant from the mother's projection and transference.

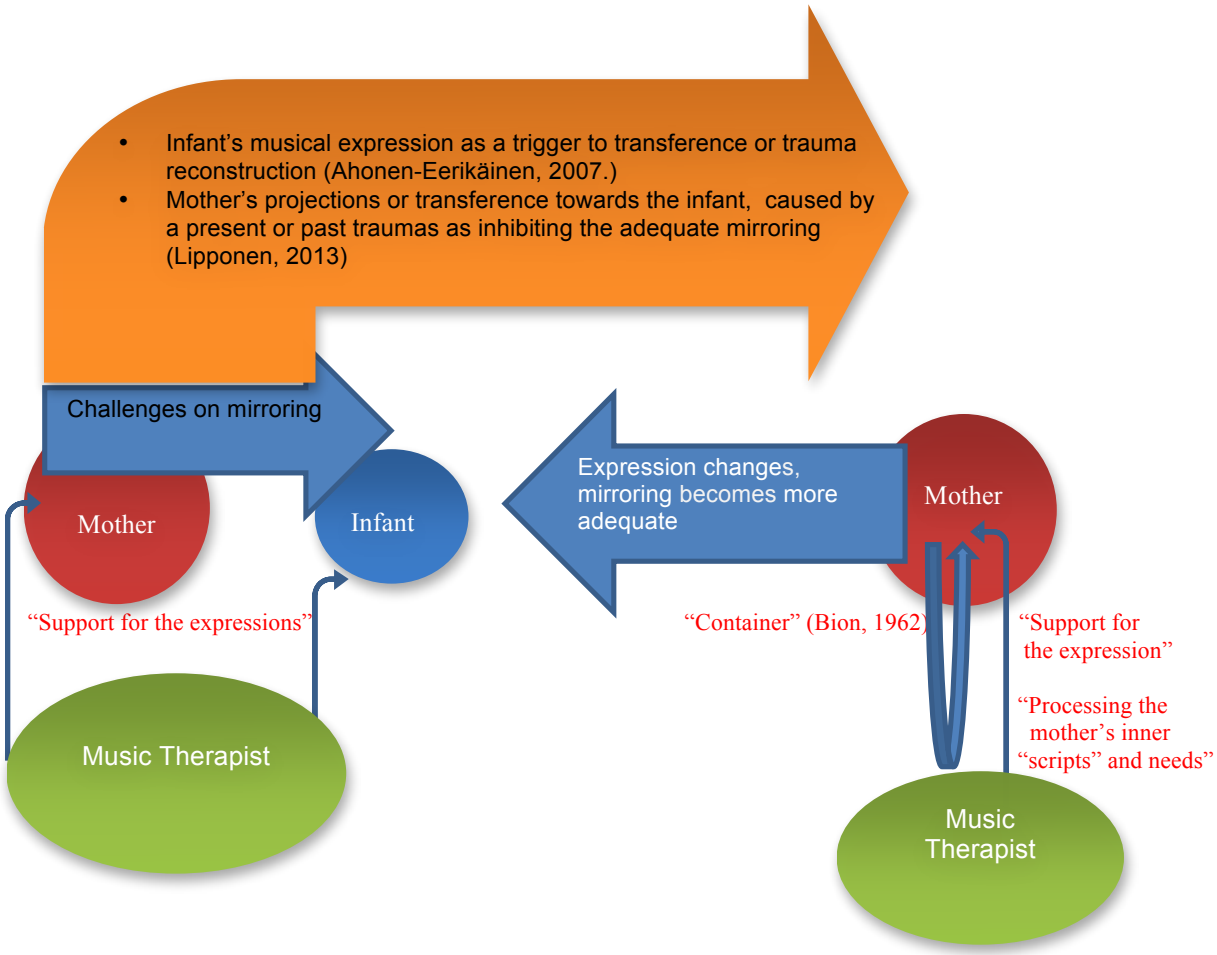
This research produced new knowledge of the second phase of the Early Interaction Music Therapy Model. This new information may be useful for early interaction treatments in the field of child protection for setting the goals and focusing the treatment and mother's own processing in an effective way. This investigation pointed out that guiding the mother to mirror her infant musically may not only bring forward the traumas of the mother's primary family interaction, but also create a transient or lasting pseudo-positive affect in the mother's interaction. Processing the mother's projections and inner images seems to be essential when compared to the guidance or support in interaction, especially in case of certain psychical symptoms of the mother.

The musical mirroring of the infant remains important in early interaction music therapy work. According to clinical experiences, it also seems quite important to have the mother present when mirroring the infant's initiatives, even when the infant is almost totally withdrawn from the contact. It allows the mother to internalize the way that the infant is invited to contact and communication and supports her to recognize the needs and reactions of her infant (Lipponen, 2003).

This research, however, also brought up the risks relating to musical mirroring guidance in situations where the mother is suffering from actual trauma or crisis, depression or psychotic features which make her an *unresponsive* A-type, - i.e. active in her own "scripts" inside, but passive as to the infant's experience of the mother's presence. It could be concluded that it may not be efficient to give guidance to this type of mothers but to observe or discuss the interaction of the infant to strengthen the reflective functioning of the mother. The challenge of mirroring the infant may turn out to be overwhelmingly stressing when the mother is not able to detach herself from her inner images in order to be able to interact with her infant in an adequate way.

Accordingly, the results of the research reveal the increasing importance of the third phase in the Early Interaction Music Therapy Model, the mother's own processing and reflection, not only of her primary family interaction and traumas, but also of her own needs, her inner images and emotions of the infant and her actual traumas or crises. It emphasizes the importance of working with the mother's projections, transference or her potential psychotic images to protect the infant from distorted interaction and its psychical consequences.

This research complemented the previous figures relating to the Early Interaction Music Therapy and the Early Interaction Music Therapy Model as follows:



Early Interaction Music Therapy

Mother's Music Therapy

9. CONCLUSION

This research investigated the theoretical frameworks of early interaction music therapy work. It presented a three phased Early Interaction Music Therapy Model and studied its effectiveness and content in a case study.

The research brought up a new perspective to the previous clinical knowledge of the Early Interaction Music Therapy Model. It emphasized the importance of processing among the primary family interaction and traumas, - also the actual crises - and the projections or transferences of the mother. By processing the mother's projections through musical improvisation and verbalizing, the infant is released from the mother's "inner, biased scripts" of the infant and their interaction is allowed to develop to a more adequate direction.

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