Therapeutic Voicework for Children with Fears and Anxieties: Developing a Model for Music Therapists

Elizabeth M. Kay

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Ph.D. Thesis

Submitted to the Senate of Bar-Ilan University

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This work was carried out under the supervision of

Prof. Avi Gilboa

Department of Music, Bar-Ilan University

Dedicated to the blessed and loving memory of

Dr. Chava Sekeles

for mentoring and inspiring me,

for always believing in me,

and for giving me the gift of her friendship.

Without her, this paper may never have been written.

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Abstract

The study presented in this paper aims to establish a model of voicework for children aged 3-10, with primary emotional difficulties, who suffer from fear and anxiety. This model is intended to provide music therapists with a foundation for treating this population. Fear and anxiety are considered common childhood complaints and music therapists frequently encounter them in their clinical work. The therapeutic benefits of voicework as informed by the professional literature have been found to be particularly significant for these difficulties. Moreover, I viewed the therapeutic potential of voicework with this specific age group and affliction as particularly promising. This position was based on my extensive clinical experience and on the correlation I perceived between the emotional condition and vocal manifestations in this population.

The main questions this research seeks to answer are: What elements may contribute to a therapeutic voicework process with children dealing with fears and anxieties? What are the stages and vocal components that are integral to a therapeutic voicework process with fearful and anxious children? How do these aspects operate in a therapeutic environment? For which clients may such a model be beneficial? Under which circumstances may such a model be considered useful and applicable for music therapists wishing to apply it?

The study commences by touching upon the therapeutic benefits inherent in vocality as documented in the professional literature from an evolutionary, developmental, neurological, physiological, and emotional perspective. Vocal interventions have been found to possess various therapeutic qualities and benefits. The voice has additionally long been established as a personal, inborn, and readily available musical instrument, central to expressing emotion in interpersonal communication. These aspects contribute to the relevancy of vocality as a therapeutic medium for children.

Despite these advantages, a review of the professional literature revealed a profound scarcity in voicework models for children. A model for children of normal intelligence and neurological development whose difficulties are emotionally based could not be found in existing writings. This was the finding despite the fact many music therapists work with such children and incorporate vocality in their clinical work. Existing models of voicework with children were found to be few and were based on the treatment of populations with special needs and cognitive, or developmental, challenges. This research therefore strives to begin to fill the void in the professional literature and to address this perceived need in the music therapy community.

This qualitative study's research approach was based on the methodology of action research (AR) and incorporated the traditional-conservative paradigm of AR. This approach enabled the voicework model developed to be actively learned, experienced, and evaluated by those practicing or studying the field of music therapy. In accordance to AR's cyclic approach, the study consisted of a spiral of cycles of self-reflection that included assessment, planning, action, evaluation, and reflection. This process endeavored to increase the studied model's relevancy, applicability, and effectiveness. The study consists of three cycles through which the model was ultimately formulated, developed, and adapted to the perceived needs of the client and emerging needs of the music therapist.

Cycle 1 served as a preliminary stage of self-examination through which the voicework model was initially established. Detailed case studies based on voicework processes of varying lengths with the studied population, alongside their accompanying clinical documentations, audio recordings, clients' products, and additional relevant materials were examined. The analytical method of document analysis was used to this end. Incorporating a reflexive approach, the ensuing findings of this analysis enabled me to outline the principles and elements of therapeutic voicework with children with fears and anxieties, and to lay the

foundations for an initial working model. In all case studies researched, the emotional pathology involved was expressed through the client's voice. The treatment process related to the vocal manifestations of the presenting difficulty, alongside the underlining emotional aspect. This served as the basis for this model's objective to treat both emotional and vocal conditions, as these were found to appear in tandem in the studied population, and to possess a mutual influence on one another.

The model's foundations included nine vocal phases and eleven vocal elements found to be fundamental to the voicework process with the studied population. Vocal phases included: Pre-vocal work, vocal togetherness, vocal liberation, vocal structuring, vocal emotional expression, vocal empowerment, vocal confrontation of fears, vocal image, and vocal processing. These phases were found to typically emerge during different stages inherent in the voicework process, correlating with their objectives.

The role of vocal use within each phase was additionally examined, indicating a general trend of the phases characterizing initial stages of therapy to typically include more use of the voice as a therapeutic factor in itself ("as therapy"). Phases including more use of the voice towards promoting an emotional objective ("in therapy"), tended to typify more advanced phases in the therapy process.

Vocal elements identified through this cycle included: Wind instrument work, singing, breath exploration, toning, primary sounds, animal sounds, gibberish, verbalization, vocalization, vocal improvisation, and ingredient variation. These were defined and categorized based on the degree of verbality and vocal improvisation they typically required from the client. These components were considered to play a role in the timing of the application of vocal phases and vocal elements throughout the therapy process. Lending to their practical application, a cross-tabulation was drawn among the vocal phases and vocal elements that indicated the frequency of each vocal element's use throughout the various vocal phases.

A hypothesis was formed regarding the clientele that may most likely benefit from this model and the therapist's multifaceted role throughout was discussed.

The defining features of the model's foundation were found to be: Structure, flexibility, versatility, and playfulness. Given the fundamental role of playfulness in general and of playful vocality in particular in this voicework model, it was decided to name it "VocaPlay Therapy".

In congruence with the study's methodology of AR, following cycles allowed scrutiny of my viewpoints, assumptions, conclusions, and course of action. This was made possible by the active assistance and participation of co-researchers.

Cycle 2 formed a basis for the ongoing attunement, refinement, testing and development of the original model established in Cycle 1. In this cycle, five experienced colleagues in the field of music therapy in Israel were selected to participate through homogeneous sampling. These therapists incorporated vocality in their therapies and were familiar with the population studied. Following the initial collection of data through questionnaires, participants viewed a specially produced video presentation of the model which summarized and demonstrated the method formulated in Cycle 1. Participants were then individually interviewed through semi-structured interviews that examined their personal and individual perspectives, impressions, and observations regarding the voicework model. The resulting materials were analyzed using IPA (interpretative phenomenological analysis).

Themes identified through the analysis of materials included: Incorporation of existing voicework models with children, principles considered important in treating the studied population, perceptions of the proposed voicework model, and considerations regarding the therapist to incorporate the model. Additional themes of relevance that emerged were: The therapist's use of her voice in therapy, factors influencing the therapist's potential use of the model in her work, and the integration of additional creative modalities in the model.

Based on these findings, conclusions were drawn regarding the model's suitability to the studied population, its potential usefulness, and possible applications in therapy. The therapist's necessary background and qualities, alongside factors considered to inhibit the therapist's use of her voice, were further considered. Thoughts on how to best incorporate vocality in therapy and general guidelines found to be essential when relaying the VocaPlay model were discussed. Based on this cycle's results, possible avenues for continued research were noted beside ways to further adjust and develop the model. Lastly, suggestions were raised to overcome this cycle's shortcomings and to expand themes for further investigation in Cycle 3.

Cycle 3 combined the initial model formulated in Cycle 1 with the concepts and modifications that evolved through Cycle 2. Participants included nine students in their second year at the Music Therapy Training Program at Bar-Ilan University in Israel. Advancing from theory to practice, the interactive media of an experiential workshop was used to relay the integrated model. Students personally experienced therapeutic interventions from the model developed thus far though simulations. These participants were selected to partake through homogeneous sampling. Data was collected through initial questionnaires, observation notes, and a focus group conducted throughout the workshop. This cycle further contributed to the expansion and attunement of the VocaPlay model by examining the fresh perspectives and experiences of these beginning music therapists. It additionally examined the participants' sense of the model's applicability.

Main themes identified through the analysis of materials using IPA included: Model presentation, participant experiencing of simulations, impressions of the integrated model, and views regarding the therapist to incorporate the model. Based on these findings, conclusions were drawn regarding queries raised in Cycle 2 as well as the most beneficial way to present the model. Additionally, the significance of non-vocal elements was assessed and the model's

applicability was evaluated. Aspects regarding the therapist and the training necessary to fully apply the model were further examined, alongside the method's suitability to different populations. Finally, the VocaPlay model’s relevance to music therapists was discussed.

The paper concludes with a summarizing chapter in which key findings regarding the model's implementation are recapitulated. The research's contributions and constraints are further clarified and possible avenues warranting future research are raised. The resulting voicework model developed through this research was found to be versatile, extensive, beneficial, applicable, and relevant for music therapists. The model was established as suitable for children suffering from fears and anxieties and additionally thought to possess the potential to treat emotional difficulties in children in general.

Introduction

The voice is our personal inborn musical instrument and a primary medium of communication and expression in human beings (Baker & Uhlig, 2011). The human voice is evident from birth when our first cry is sounded, followed by additional instinctive sounds (such as laughter, babbling, sighs, and screams). It possesses the ability to express every emotion known to man (Benninger, 2010; Heman-Ackah, 2009; Martin, 2009). From the very beginning of life, the child is soothed and reassured by the mother's (or primary caretaker's) voice (Papoušek, 1995, 1996). The continuous and stable presence of this voice in his life signifies that he is cared for, loved and not alone. This voice is ideally attuned to his needs and affective state and modified according to the caretaker's perception of these (Stern, 1985). A mother may therefore sing lullabies, coo and change the tone, contour, rhythm, volume or quality of her voice to calm the infant. She may also meet the baby on his level of communication by babbling or speaking gibberish, thereby recognizing, supporting and reinforcing his vocal presence and expressions (Malloch & Trevarthen, 2009). These and other vocal interactions, present from birth between mother and baby, have been recognized as an essential source of bonding, forming the basis for the child's interpersonal interaction and emotional communication, alongside the development of a sense of self (Malloch, 1999).

For over centuries, vocal expression has been used to cope with and transform emotions (Uhlig, 2006). The origins of vocalization predate the development of spoken language, and its practice in promoting communication, health, well-being, and in creating community is an ancient ritualistic art (Austin, 2008; Koopman, 1999). Moreover, singing has been documented as a central component in the traditional healing rituals of non-literate societies, which form the earliest origins of the music therapy profession (Sekeles, 1990, 1996).

Voicework additionally possesses the potential to be a powerful therapeutic agent from a neurological perspective, specifically for those who lack verbal dexterity (such as children).

Singing has been found to activate distinct regions on the emotional right hemisphere accountable for emotion perception, processing, and control far more intensely than speaking (Bourne & Hole, 2006; Ozdemir et al., 2006; Smith & Bulman-Fleming, 2006). The right hemisphere has further been found to be dominant for the expression of spontaneous and intense emotions and the non-verbal communication of emotions (Blonder et. al, 1991; Schore, 2003), as well as in self-awareness and in empathy (Schore & Schore, 2008).

Despite the voice's many beneficial qualities and music therapists' frequent use of vocal interventions in their clinical work throughout the world (Baker & Uhlig, 2011), there is a scarcity of literature addressing the emotional benefits of vocal interventions in music therapy. This is especially true in regards to voicework with children. This is surprising, considering that many music therapists work with young children (Carr & Wigram, 2009; Halverson-Ramos et al., 2019). Most voicework models have been designed specifically for adult populations, consistently disregarding children, in particular children with normal cognitive functioning. Thus, a model for therapeutic voicework for children with primary emotional difficulties has yet to be formulated. The current study aims to partially fill this gap in the literature. It focuses on developing a model of voicework for children of normal intelligence and cognitive functioning, suffering from the common and prevailing childhood complaint of fear and anxiety (Beesdo, Knappe & Pine, 2009; Ollendick, Hagopian, & King, 1997; Olendick & Seligman, 2012). The therapeutic benefits voicework holds for children with this condition is especially significant, given the potential vocal activity has to decrease anxiety, induce relaxation, develop entrainment, modulate states of arousal, and promote stress management, as well as advance social interaction and emotional expression (Malloch & Trevarthen, 2009; Ritz & Roth, 2003; Schore & Schore, 2008; Stern, 1985; Uhlig, 2006).

Literature Review

This study's objective is to develop a voicework model for children with fears and/or anxieties with intact cognitive functioning. Therefore, the condition of childhood fear and anxiety will be defined and its manifestations, pathological presentations, and current interventions will be reviewed in this section. Existing emotionally oriented voicework models for different age groups and populations will be subsequently examined and summarized. This review brings to light the relevance and importance of treating the condition of fear and anxiety in children, alongside the void in the professional literature in regards to voicework with the studied population.

Childhood Fear and Anxiety

Definitions. Fear is a phenomenon that has been extensively researched, commencing in1897 and continuing up till this day, with over 100 studies carried out on the topic (Gullone, 2000). Many different definitions of the term 'fear' may be found in the literature. Fear is typically defined as a normal emotional response to a perceived threat that may be either real or imagined (Lefrancois, 2001; Morris & Kratochwill, 1983). Therefore, it is considered an integral part of normal human functioning. Anxiety has been defined as apprehension or excessive fear about real or imagined circumstances (Lefrancois, 2001). The central characteristic of anxiety is excessive concern about situations with uncertain outcomes. Symptoms may affect thinking, behavior, or physical reactions. Anxiety is generally adaptive and initially functions to facilitate avoidance of danger and protection against harm (Costello et al., 2003).

Manifestations of fear and anxiety in children. Fear may first be observed in the infant as a reflexive response to loud noises and fear of falling, and later in the six-month-old as a fear of strangers (Lefrancois, 2001). Anxiety generally first manifests itself in children as separation anxiety at 12-18 months (Costello et al., 2003). Though nearly all children

experience some degree of fear and anxiety and normal fears typically continue to be present throughout one's life, they are generally mild, age-specific, and transient (Ollendick, Hagopian & King, 1997).

Pathological fear and anxiety in children. Anxiety disorders are common and early emerging conditions. Studies have indicated that anxiety disorders are the earliest of all forms of psychopathology, with fears and anxieties first appearing as early as infancy (Muris et al., 1998). They are additionally the most frequently diagnosed class of disorders in children an in adolescents (Olendick & Seligman, 2012), with a lifetime prevalence of pediatric anxiety of around 15–20% (Bushnell et al., 2019). Childhood is considered the core risk phase for the development of anxiety symptoms and conditions (Beesdo, Knappe & Pine, 2009).

Both fears and anxieties may be considered pathological and thereby harmful to a child's development if they meet specific distinguishing factors. Fear is perceived as pathological when it is excessive in relation to the situation, cannot be reasoned away, is beyond voluntary control, leads to avoidance of the feared object or situation, persists over time, is maladaptive, and is not age specific (Ollendick & Francis, 1988).

According to the American Psychological Association (2013), anxiety is considered pathological when it is persistent (present for at least six months), interferes with functioning, and is frequent or severe. It may be associated with avoidance behavior or subjective distress in the child when he is faced with certain situations. Anxiety may therefore negatively affect a child's quality of life. Anxiety disorders in children include separation anxiety disorder, selective mutism, specific phobia, social phobia, agoraphobia, panic disorder, and generalized anxiety disorder (American Psychological Association, 2013).

Anxiety disorders in childhood are further associated with considerable complications over the course of life. They are considered risk factors for the development of further anxiety disorders, depressive disorders, substance abuse or dependence, impaired academic

achievement, emotional disability and suicidal behavior later in life (Bushnell et al., 2019; Wittchen et al., 2003; Woodward & Fergusson, 2001). These findings indicate the sustained impact of unmanaged anxiety and the importance of early diagnosis and intervention in children displaying signs and symptoms of anxiety. Effective and timely treatment was found essential in order to manage symptoms and improve quality of life as well as reduce the persistence of anxiety into the child's future (Bushnell et al., 2019).

Current interventions. The most common treatments for children with anxiety disorders are cognitive behavioral treatment (CBT) and pharmacological treatments.

Cognitive behavioral therapy. CBT is considered an evidence-based psychological treatment (Ollendick, King & Chorpita, 2006). It is aimed at modifying both overt behaviors as well as attitudes, beliefs, cognitive styles and client expectations (Galeazzi & Meazzini, 2004). CBT methods for childhood anxiety disorders originally emerged from two areas of experimental psychology: Learning theory and cognitive psychology (Olendick & Seligman, 2011). The therapeutic process includes the client's appropriate recognition of their emotions and discrimination of their thoughts, feelings and behavior (Halder & Mahato, 2019). Techniques include behavior rewarding systems, graduated exposure to frightening objects or situations, relaxation techniques, promoting awareness and modification of negative thoughts, as well as modeling desired behaviors (Velting, Setzer & Albano, 2004).

Today, CBT is used in a variety of settings including schools, outpatient clinics, primary care practices and in inpatient or partial-hospitalization programs (Olendick & Seligman, 2011). Existing and growing literature on the use of CBT for the treatment of anxiety disorders in children include research of its use in specific settings (Miller et. al., 2010), in specific anxiety disorders (Ostergaard, 2018; Reuther et al., 2011), and for certain phobias (Donovan et al., 2017; Simon et al., 2020).

However, CBT requires a certain level of cognitive, linguistic and adaptive capabilities, alongside patience, tenacity, and maturity (Halder & Mahato, 2019). These may pose a significant barrier when treating young children, as: "Identification of automatic thoughts and distinguishing different emotional states and linking of these emotional states with thoughts and events could be a difficult one with children" (Halder & Mahato, 2019, p. 281). It is therefore necessary that CBT undergo modification in order to be applied in the treatment of young children (Minde et al., 2010).

Pharmacological treatments. Multiple pharmacological interventions exist for treating anxiety in children. The American Academy of Child and Adolescent Psychiatry (AACAP) only recommends such interventions for anxiety in children when moderate to severe symptoms or comorbid psychiatric disorders are present. It additionally endorses pharmacological treatment when children are unable or unwilling to participate in psychotherapy or do not fully respond to it (Geller, March & AACAP Committee on Quality Issues, 2012).

Throughout the years, anxiolytic benzodiazepines, tricyclic antidepressants and new generation antidepressants have all be used to treat anxiety in children (Williams & Miller, 2003). However, benzodiazepines are usually recommended exclusively for short-term treatment given dependency concerns (Ipser et al., 2009). Today, selective serotonin reuptake inhibitors (SSRIs), an antidepressant, is the most commonly used first-line medication for pediatric anxiety (Bushnell et al., 2019).

All pharmacological interventions carry the risk of side effects and all antidepressants now carry a black-box warning for an increased risk of suicidality in children (Leslie et al., 2005). It is noteworthy that SSRIs are not currently approved by the US Food and Drug Administration (FDA) for pediatric anxiety that is not considered to be obsessive-compulsive disorder (OCD). Additionally, there exists limited evidence on the long-term efficacy and

safety of anti-anxiety medications for children and the benefits and risks of long-term SSRI use have yet to be studied. These findings raising concern over the potential harms of routine pharmacological anxiety treatment (Creswell, Waite & Cooper, 2014).

Models in Therapeutic Voicework

Therapeutic voicework with adults. Pioneering models created in the field of psychologically informed voicework pertained to work with adult clients, usually neurotic and of normal intelligence. They form the greater part of existing psychotherapeutic voicework models today (Austin, 2004, 2008; Newham, 1998, 1999; Sokolov, 1981, 1987, 2002). These models are based on Jungian concepts, integrating perspectives and techniques from various disciplines, with the body-mind connection central to them all. In these approaches, the client is actively vocal, creating verbal or non-verbal sounds through free or guided vocalizations, singing, and vocal improvisations. The therapist may incorporate his or her own voice in the expressive process for therapeutic objectives, with vocalizations generally taking on a guiding, supporting, encouraging, comforting or modeling role. This may be compared to a mother's use of her voice when attempting to elicit vocalizations or otherwise interact vocally with her young infant.

Sokolov developed "Embodied Voice Work", a vocal model in which free vocalization and awareness are the bases for therapeutic change (Bruscia, 1987; Sokolov, 1981, 1987, 2002). Her approach is based on a wellness model, and integrates ideas from various schools of thought (Appendix A). Carl Jung's notions of the personal and collective unconscious and the use of symbolism and archetypal imagery are especially relevant to Sokolov's work (Bruscia, 1987), as she uses vocal improvisations to elevate awareness of self and others, as well as to access preconscious and subconscious materials and resources. Developmentally sequenced exercises assist each person in accessing the information and musical instinct within the body. The client's resources are discovered and unleashed through the process of finding

and freeing one's voice. Sokolov's method was originally designed for therapeutic work with normal and neurotic adults and later applied to pain sufferers, stroke and cancer patients, adult psychiatric patients, and in childbirth. Her clientele is mainly verbal and of normal intelligence. Her model incorporates breathing techniques, toning, free vocal improvisation, practicing attentiveness, singing, body alignment, touch, verbal imagery, and psychotherapeutic techniques with individuals, groups, and families. Therapeutic goals may include: expanding vocal, physical, and expressive flexibility and range; pain and stress reduction; releasing emotional, physical and intellectual blockages through voicework; and encouraging communication between various aspects of the self (Bruscia, 1987). Her ultimate goal is to "embody" the voice; to aid each individual in cultivating the unique sound and expression of his/her body (Sokolov, 2002). While the voice is the primary medium for both therapist and client, musical instruments, movement, and drawing are incorporated into the process as needed. Vocal discussions and processing are considered a central part of this approach.

Paul Newham's methodology is an integrated expressive arts therapy entitled "Voice Movement Therapy" (VMT) (Newham, 1997, 1999). The role of vocal expression in emotion regulation and psychopathology is central to VMT. Newham's methodology integrates the psychological, physiological, artistic and educational aspects of vocal work. It includes analyzing clients' voices and developing their artistic and emotional expression based on ten acoustic components which emanate from physiological and psychological functioning (Newham, 1997). VMT is based on the pioneering methods of vocal facilitator Alfred Wolfsohn and influenced by the theatre work of actor and director Roy Hart; the acoustical analysis of otolaryngologist Dr Paul Moses; the characterological bodywork of Wilhelm Reich; and the psychological principles of the active imagination, archetypal and sub-personality work conceived of by C.G. Jung. Newham began his work with non-verbal populations with severe mental and physical handicaps. He aimed to aid them in communicating vocally through

affective or expressive sound and theatrical enactments. He then extended his work to the neurotic adult whose vocal expressivity had been damaged due to emotional problems, trauma, disease, environmental influences, or innate disabilities. His goal focused on expanding and strengthening their vocal abilities and promoting an exploration of their issues through voice. This was achieved by creative enactment of clients' personal stories in movement and song, alongside releasing their vocal function from constriction and liberating the clients' “authentic voice". VMT techniques incorporate the use of voice with movement, dance, massage, creative writing, singing, sound making, drama, and performance. This system may be applied in individual or in group therapy.

Diane Austin (1993, 2002, 2004, 2008) refers to her analytically oriented approach as “Vocal Psychotherapy”. It is applied in individual therapy, mainly with neurotic or high functioning adults, though she also mentions work with adolescents. This model integrates the practice of music psychotherapy with theories from depth psychology, trauma, and addiction treatment. It stresses the symbolism of the vocal improvisations, approaching them from the Jungian perspective that the voice contains information from the deep past that is shared by all human beings (Austin, 1993). Austin also bases her work on object relations (Winnicott, 1971) and writes about the use of voice to repair early mother-child ruptures. She defines her work as “a creative process that utilizes music and words with a client/therapist relationship to facilitate an ongoing dialogue between the conscious and unconscious contents of the client’s psyche” (2004, p.12). Methods unique to this model and researched in her qualitative study (2004) include vocal improvisation approaches termed “vocal holding techniques”. These are usually based on an alternating two chord harmonic structure provided on the piano, above which the client and therapist both vocally improvise. The stages of vocal holding are meant to complement developmental stages by mirroring mother-infant vocal interactions and may include singing in unison, harmonizing, mirroring, and grounding. Clients may also be

encouraged to spontaneously sing words while the therapist intervenes both verbally and musically (*free associative singing*), a method which is reminiscent of Freud's (1938) technique of free association. These explorative vocal improvisations aim to help the client "give trauma a voice" and integrate a "fragmented self" (Austin, 2002).

Sanne Storm (2013, 2018) has more recently contributed to the growing research in this field of voicework by developing a detailed assessment tool for the voice which she terms "Voice Assessment Profile" (VOIAS). This tool communicates important observations of the human voice in music therapy. It was developed following Storm's examination of the clinical applicability and relevance of the voice as an assessment tool (2013). The assessment profile incorporates both theoretical and practical approaches in its attempt to psychologically interpret the client's vocal expressions. Storm has concluded through her research that selected vocal parameters can describe and evaluate vocal sound, its expression, and its dynamic forms of vitality, therefore aiding in evaluating a client's state of being. She writes on how the sound of the client's voice, and the changes that develop in it, reflect the therapeutic process he undergoes. She believes, for example, that "a full, harmonic or balanced sound usually reflects a vital and balanced state of the patient" (Storm 2018, p.317). In VOIAS, assessment is carried out through vocal exercises and entails observing and evaluating the voice from varied perspectives. The assessment includes a subjective analysis of evaluating vocal sound data as well as an objective psychoacoustic analysis using soundwave software.

Therapeutic voicework with infants. Literature may be found on vocal music therapy with newborns and infants that investigates the benefits of the caretaker singing to an infant who takes on a mainly passive, auditory processing role (Baker & Mackinlay, 2006; Cevasco, 2008; Courtnage, 2001, 2009; de l'Etolie, 2006; Gilad & Arnon, 2010).

Significant research additionally exists by theoreticians such as Daniel N. Stern, Stephen N. Malloch and Colwyn Trevarthen who view the infant as intersubjective and address

aspects of social-emotional development. Stern (1985, 2002, 2010) researched “affective attunement” and “forms of vitality”. He observed that infants communicate through vocalizations long before language development takes place. Through the voice they communicate their basic needs as well as changing affective states. Caregivers respond to these non-verbal vocal sounds interactively by attuning their won vocality to the infant’s expressions. They may imitate, develop, extend or exaggerate musical aspects of the infant’s vocality. Stern views the affective sharing inherent to these interactions to be central in intersubjective relatedness and in the parent’s empathic responsiveness. He believes that the infant senses the caretaker’s gesture as an affirmation of his affective state. This emphasizes to the infant recognition of internal, affective states, as though the caretaker has understood not only his behavior, but the feeling behind it. These early interactions in which he is recognized and confirmed by the caregiver is further thought to shape and influence the infant’s experience of a feeling of vitality related to feelings of agency and efficacy. This vitality is thought to confirm an integration of the self and to represent a constant and underlying lived experience in the personal life as well as in relationships with others. Stern therefore postulates that it is through such vocal exchanges that children learn to interact with others as well as develop both socially and emotionally. In this way the voice provides a primary medium for interpersonal relationships and for human communication.

Malloch (1999, 2009, 2012) and Trevarthen (1998, 2000, 2001, 2008) studied “communicative musicality” and infant communication, exploring the intrinsic musical nature of human interaction. The concept of communicative musicality is based Malloch’s (1999) acoustic analyses of sound dialogues between mothers and infants. These studies demonstrated how in mother-infant communication there exist noticeable musical patterns such as voice timbre, rhythm, timing and intensity. Accordingly, musicality was viewed as an innate, inherently communicative language. Infants and mothers are moreover believed to have

intuitive access to each other's subjective states, which enables reciprocal coordination of their emotions and behaviors. This dynamic experience, during which caregivers may attune themselves to infants by matching the emotive forms of vitality inherent in their communicative musicality is thought to be fundamental and to form the basis of human experience and sense of aliveness. This parental attunement is further believed to affect the attachment style formed by the infant.

Helen Shoemark (1999, 2006, 2010, 2011) has contributed to the latter approach by developing a method of therapeutic voicework with young infants in which the therapist attempts to engage the infant through vocal interaction. During this interaction, the therapist adapts her vocalizations to the infant's ongoing changing needs, while guiding him towards therapeutic goals pertaining to interpersonal capabilities. Shoemark researched the application of the knowledge divulged from Fernald (1989) and the Papouseks (1991) on patterns of infant-directed speech for therapeutic benefits with hospitalized newborn infants and for pre-term infants. Using singing in an individual setting as a therapeutic medium with medically fragile infants has been claimed to be effective. This is due to its containing and engaging qualities, the fact that it requires no further conscious processing of the experience on the part of the infant, and the predictability present in song format (Nakata & Trehub, 2004). In addition, singing enables the therapist to respond to the infant from moment to moment, adapting the mutual vocal creation to his varying needs and reactions. Shoemark's unstructured approach is informed by spontaneous infant-directed singing and speech, normally used by caregivers, with the music therapist consciously employing maternal-infant communication attributes in her singing and speech, as well as in accompanying gestures and facial expressions. During this process, the therapist intentionally decides how to proceed, based on the infant's therapeutic objectives. She structures and guides the therapeutic interplay based on ongoing interpretations of the progressions and infant's various cues. This often involves the therapist modifying her

vocalizations to stimulate, soothe, engage or distract the infant or to support or encourage specific infant interplay. Vocal techniques employed include singing, humming, chanting, improvised vocalizations, nonsense lyrics, repetitive melodic themes, and semi-sung motifs. Research discovered that infants involved in this "contingent singing" method were better able to maintain self-regulation during the interaction with the attuned adult: they were less irritable, cried less and reacted more favorably to adult handling (Malloch et al., 2012).

Therapeutic voicework with children and youth. There exists much mention of the technique of songwriting and its benefits with children and youth within the music therapy session (Baker et al., 2008; McFerran, 2006; Wigram & Baker, 2005). Case studies may additionally be found presenting examples of therapeutic vocal work with different age groups with special needs (e.g., Boswell & Vidret, 1993; Heal, 1989; Nordoff & Robbins, 1971; Tomlinson et al., 2012; Warnock, 2012). Marie-Victoire Cumming (2011) has further contributed to this topic through a qualitative study which explores the benefits of vocal activities in group music therapy with institutionalized children and adolescents (aged 9-17) with cerebral palsy (CP). These clients suffered from cognitive impairments and lacked the ability to communicate verbally. Her findings indicated that vocal interventions incorporated throughout eight group sessions allowed members to feel heard, recognized and validated within the group. This led to an increase in their self-esteem and enhanced their capability to express themselves and to experience acknowledgement of their abilities within the sessions. Cumming concluded that the vocal music therapy sessions ultimately provided these clients with opportunities for self-expression and meaningful interaction.

However, it appears that aside from Austin's and Sylka Uhlig's contributions to voicework in which they mention including adolescents (Austin, 2004, 2008; Uhlig, 2011a, 2011b) insufficient research has been done regarding the beneficial effects of individual voicework on the psychological well-being of youth. Moreover, no model for children

suffering from primary emotional issues could be found in the professional literature. Apart from the following two suggestions described below which are intended for children with cognitive, neurological, or developmental challenges, no comprehensive model for voicework with children has yet been offered.

Tina Warnock (2011) writes of the improvisational use of the voice in music therapy with mainly autistic patients of varying ages, including children and youth. Her approach proposes that "the voice is connected to the sense of self, which is connected to the quality of interaction with the mother, which is in turn linked with the development of the voice" (p.7). Reminiscent of Austin's model (2004), she aims to recreate the mother-infant relationship in the therapeutic vocal relationship, where she identifies developmental processes taking place for the client. Warnock demonstrates through case studies how non-verbal vocal work can stimulate development of the self, provide opportunities to develop interpersonal skills, and facilitate self-awareness. She suggests that vocalization alone, without the need for verbal interpretations, suffices to achieve these results. Warnock bases her clinical work on theories of the self (Stern, 1985; Winnicott, 1960, 1971) and incorporates vocal techniques which replicate pre-verbal modes of interaction to develop interpersonal relating, self-awareness and acceptance, and the voice itself.

Sylka Uhlig (2011a, 2011b) wrote a case study on the effects of her proposed method of "Rap Music Therapy" in individual therapy on the emotional and cognitive development of at-risk multi-problematic children and youth (aged 5-12) with special needs in a public school setting in New York City. The population considered was predominantly African-American and Hispanic, from problematic home environments, often suffering from developmental delays or disorders, autism, Down's syndrome, speech difficulties, concentration problems and learning difficulties. Uhlig (2011a) defines rap as "a primary vocal expression of emotional and cultural values sustained by a rhythm" (p .73). She proposes the facilitation of the voice as

a vehicle through which to express frustration and aggression, aiming for aggression regulation and enhanced self-esteem alongside the stimulation of cognitive development, through working with rap. Uhlig stresses the cultural, social and emotional value of rap singing with this population and the neurological stimulation of its rhythmic component. She describes how chaotic emotions can be given structure largely through primal vocal expression that includes singing, rapping and shouting.

Similar to Warnock's approach, Uhlig does not deem verbal processing necessary for the therapeutic process to be successful. A variety of verbal processing techniques which may also be applied to children do however exist in music therapy texts (Nolan, 2005). Furthermore, examples of therapy with children in which verbal processing is implemented may be found in the creative arts therapy literature (Herman, 1991; Rubin, 1984).

To summarize (Appendix A), voicework models with children mentioned in the literature are sparse and not yet fully developed. No research based model for emotional centered voicework with children of normal intelligence suffering from fears and anxieties could be found. Existing voicework models are primarily based on case studies and focus on special needs populations facing cognitive and/or developmental challenges, and less so, children whose difficulties are predominantly emotional. Though Uhlig's contribution to this seemingly otherwise desolate area of research is essential, the designated clientele for her proposed form of therapy appears quite restricted, as the cultural and social significance of the musical form used (rap singing) appears to hold much consequence in the effectiveness of her method.

Moreover, the clinical populations studied in voicework models consistently neglect children with normal cognitive functioning. Both models mentioning work with children (Uhlig, 2011; Warnock 2011) do not relate to the topic of verbal processing in therapy, deeming

it “unnecessary”. Furthermore, they do not incorporate in the therapy additional mediums beyond vocality and music.

The Present Study

The proposed research aims to take a first step towards filling the void in the professional literature by focusing on developing a vocal model to treat children suffering from the common childhood condition of fear and anxiety. It will draw from clinical experience and from selected voicework concepts adapted to the clinical population studied, and will integrate principles of therapeutic play (Russ, 2004; Winnicott, 1971).

Research Objective

The objective of this research is to formulate a model of voicework with children of normal intelligence suffering from fears and anxieties that will serve as a basis for therapy. Initial research questions underwent alterations as the research advanced through the cycles of participant cooperation and participation (Marshall & Rossman, 1999). The study seeks to answer the following questions: What elements may contribute to a therapeutic voicework process with children dealing with fears and anxieties? What stages are integral to a therapeutic voicework process with fearful and anxious children? What are the vocal components that may contribute to the therapeutic process? How do these aspects operate in a therapeutic environment? For which clients may such a model be beneficial? Under which circumstances may such a model be considered useful and applicable for music therapists wishing to apply it?

Research Approach

Multiple research tools were used in this study to collect data. These include case studies, questionnaires, partially structured individual interviews based on a video presentation of the model, therapist observation notes and a focus group conducted throughout a workshop on the model studied.

This research project is based on the methodology of action research (AR). AR is a well-documented long standing tradition of collective inquiry and experimentation which is supported by fact finding, evidential reasoning, and experiential learning (Reason & Bradbury, 2008). The purpose of this methodology is to produce practical knowledge that is useful to people in their everyday conduct, as well as "…to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people…" (Reason & Bradbury, 2001, p.1). Mahone and colleagues (2011) view AR as an effective way of enhancing the relevance of scientific research and improving the adoption of evidence-based practice in health care. This approach enabled the active experiencing and evaluation of the voicework model studied by those who it may be of most interest to, subjecting it to a process which strived to ultimately lead to its increased relevancy, applicability and effectiveness.

The change promoted in this research is a change in the practice of voicework with children with fears and anxieties. This goal will further my professional development as well as that of the participants, leading to more proficient therapeutic voicework with children, while expanding the variety of therapeutic tools available to music therapists. Thus, the study seeks to create a change in the field of music therapy and to contribute to its professional development in society. Ultimately, the research aims to contribute to society by improving the quality of life of those who may be aided by the model that this study seeks to develop.

Zellermayer (2001) differentiates among 3 types of AR: The traditional-conservative paradigm, the participatory-practical paradigm and the emancipatory-critical paradigm. The traditional-conservative paradigm of AR has been chosen for this research. The basic stance of this paradigm is that researchers naturally possess knowledge and authority in the field studied, rendering hierarchical relationships between the researcher and the study's participants customary. This particular stance is appropriate for this study, given the hierarchical nature

inherent in the research tool of the workshop applied in Cycle 3 and in the analysis method in both cycles.

AR has been used in research in the field of music therapy. AR has been employed by Gang (2009) as well as by Hunt (2005), who applies this methodology to research refugees in her article on group music therapy with young refugees in a school community. One of her findings was that the use of AR contributed to the empowerment of the population studied and allowed them to experience a sense of personal and community belonging.

AR is based on a cyclic approach that allows all involved in the research to learn from the process (Stige, 2005). Cycles include assessment, planning, action, evaluation and reflection.

Research Outline

The current study includes three cycles through which the vocal model is formulated and developed.

Cycle 1 serves as a preliminary stage of self-examination through which the model is initially established. Detailed case studies based on voicework processes of varying lengths with the studied population alongside their accompanying clinical documentations, audio recordings, clients' products and additional relevant materials are examined. Ensuing findings enable me to outline the principles and elements of therapeutic voicework with children with fears and anxieties and to lay the foundations for an initial working model. The main research questions are: What therapeutic elements may contribute to a voicework process with children with fears and anxieties? What vocal components may contribute to the therapeutic process? What phases and stages may prove integral to the voicework process? How do these aspects operate in a therapeutic environment? For which clients may the voicework model prove beneficial? Under which circumstances may such a model prove useful and applicable for music therapists?

In Cycle 2, experienced colleagues are exposed to the model via a specially produced video presentation and are subsequently interviewed on it. Examination of participants' perspectives, impressions, and observations regarding the model forms a basis for the ongoing attunement, refinement, testing and development of the original model established in Cycle 1. The main research questions are: What are experienced music therapists' perspectives, impressions, and observations regarding the model formulated in Cycle 1? Is the initial model appropriate for children with fears and anxieties? How may the initial model be developed and improved? What factors may facilitate or hinder music therapists' use of the model? Who is the therapist best suited to incorporate this model?

In Cycle 3, an experiential workshop relaying the integrated model developed through previous cycles is conducted with music therapy students. A focus group is then formed to determine the model's applicability for this participant group of beginning music therapists and to obtain their fresh perspectives on the model developed through the previous cycles. The main research questions are: How is the integrated model experienced, accepted and perceived by beginning music therapists? What is this group's sense of the model's applicability? How may the integrated model be further developed or modified? Are there additional populations that may benefit from the model? Do the members' perspectives solidify or challenge previous findings? What training would be required for music therapists to incorporate the model in their work?

Each cycle is described separately, indicating in every one who the participants are, the tools employed, procedure planned and the model used to analyze the materials. In addition, ethical issues that may arise in each of the cycles and ways they are dealt with are addressed. Finally, conclusions relating to this study's research objective are drawn and discussed and options are raised for future research on this topic.

CYCLE 1

Method

In this preliminary stage of self-examination, my personal documented clinical experiences with the voicework approach were examined through case studies. This stage served as the foundation for the voice therapy model studied and developed throughout this paper.

Tools

Case studies based on voicework processes with three clients between the ages of approximately 4-10 with fears and/or anxieties were selected through purposive sampling. Clients in the case studies sampled had been referred to therapy based on either a psychological diagnosis or the caretakers' or learning institution's suspicion of fear or anxiety. These case studies include processes with clients with varied emotional conditions originating from anxiety and fear for whom the voice was the main therapeutic medium used throughout their process. In these cases, the emotional pathology involved was expressed through the client's voice and was treated accordingly through the voice. Treatment related to both the vocal aspect of the presenting difficulty alongside the underlining emotional aspect. The technique of heterogeneous sampling (Patton, 1990) was used to attempt to identify common themes evident in the voicework depicted in the case studies. Treatments sampled include short, medium and long term therapy processes, ranging from three months to four years, of children who have undergone therapy with the model studied.

Data Collection

Data was collected through approximately 100 pages of handwritten detailed clinical documentation of therapy sessions and observations, roughly 50 audio recordings of vocal segments of the therapy, psychological test results and reports, numerous caregiver reports and over a dozen of patients’ artistic products (e.g. compositions, drawings, creations). The

children's age, diagnoses, family background, the duration of therapy, and all additional relevant information that may arise will be indicated in the study.

Analysis Method

Analysis of the content and processes inherent in clinical materials led to the summarization of the voice therapy process undergone in each case in the form of case studies and to the formulation of their accompanying outlining tables (Appendix D). These detailed clinical case studies examined the role of voicework in the therapeutic process and the contribution of incorporating specific voicework techniques in the treatment of children with fears and anxieties. Analysis was achieved using document analysis.

Document analysis is an analytical method in qualitative research for systematically reviewing and evaluating various forms of documents in such a way that empirical knowledge is produced and understanding is developed (Bowen, 2009). The analytic procedure entails finding, selecting, appraising and synthesizing data contained in documents that are subsequently organized into major themes, categories and case examples. This is accomplished through content and thematic analysis (Labuschagne, 2003). Qualitative content analysis is an approach of empirical, methodological and controlled analysis of texts within their context of communication. This is achieved while following content analytical rules and step-by-step models, without rash quantification (Ghetti & Keith, 2016).

Throughout this procedure, data from historical background and psychological reports were used to provide data on the context within which the research participants operated. Clinical documentation was then examined through this method while incorporating a reflexive approach to track clients' change and development and to elicit an understanding of the stages inherent in this process and the role of voicework in the patients’ progress. Furthermore, caregiver update reports, audio recordings and artistic products such as compositions, drawings and visual art creations were examined and interpreted through this method to provide

supplementary research data and to verify findings or corroborate evidence from the additional sources. Ongoing comparisons among the diverse case studies and their corresponding tables led to the detection of recurrent themes central to the voice therapy process. Similarity and disparity among these themes and their connotations were closely examined. This led to a reduction in their number, as commonalities were found among the therapeutic aims underlining these themes, enabling them to be eventually converged under more inclusive labels. These labels were repeatedly adjusted to attempt to reflect the overall objective underlying them. Definitions accurately denoting the implications of these labels were sought after through reviewing the contribution and significance of their content in each case studied. Analysis of the data in this cycle enabled me to delineate the principles and concepts of voicework with children with fears and anxieties and to lay the foundations for a working model.

Ethical Issues

This study was approved by the ethical committee of the Music Department at Bar-Ilan University, Israel (Appendix B).

[1]Caregivers of children whose case study was used for the research were requested to sign an informed consent form (Appendix C) permitting documentation of the child's therapy to be used in the research. Children whose case study was used were informed of the research and their oral consent was obtained. Identities of clients were kept strictly confidential, in accordance with patient confidentiality laws (Flewitt, 2005). In order to achieve this and to ensure the anonymity of the participants, all names mentioned throughout this study are

[1] Children are not legally competent to give consent. Therefore, when using children as research subjects, it is necessary to obtain informed consent from the child’s legal guardians.

pseudonyms. In cases where a child's story could possibly identify them, personal details were at times altered or omitted so as to disguise identifying details.

Findings

Three case studies depicting therapeutic processes of varied lengths (from the longest to shortest process) in voice therapy with children suffering from diverse fears and anxieties are presented. These clinical case studies examine the role and unique contribution of voicework in the therapeutic process with the population studied. These will serve as a foundation for the development of an initial working model of therapeutic voicework with children suffering from fears and anxieties. The cases will first be described and will then be analyzed to tease out principles upon which the voicework model will be based.

Case Studies

Case study 1.

Background. Shira[2], age 4.5, was born following a very high risk pregnancy which required her mother be restricted to bed rest early on. The youngest of two, her overall development was standard, however her parents described her as being born with a "nervous" temperament and suffering severe sleep difficulties for the first years of her life. At two years of age, she would at times vomit when she wouldn't get her way. Shira was described by her parents as bright, cheerful, artistic, energetic, playful and impulsive. She would often become frustrated when she didn't succeed in expressing her needs and would then revert to crying, screaming and hitting. Though she was very talkative, she was verbally inhibited when expressing emotions. Pastimes she enjoyed included singing and playing the harmonica at

[2] Clients' names were altered to protect confidentiality

home. She would often request for the volume to be turned up when music was played, though no hearing irregularities were detected. Her everyday speech was unusually (sometimes painfully) loud and she would often shout, though she exhibited a fear of loud sounds.

Shira's mother had a history of various illnesses, mostly dating back to her pregnancy with Shira. She been feeling especially ill for a while, and was scheduled for a surgical procedure. The parents described a very strong attachment between Shira and her mother, whom she spent most of her time with. Her attitude towards her was described as possessive, often demanding she have her to herself and apparently resenting her sibling's presence. Her father would work long hours and return home late in the evening and would frequently be absent for long periods of time as his work required oversea travel. Shira's relationship with him was described as ambivalent, with her often seeking affection from her father and subsequently pulling away.

Though fully toilet trained by the age of 2.5, Shira had begun to wet the bed for the past few months. She had also begun to suffer from nightmares, feared to sleep alone and would call out to her mother throughout the night. She would often revert to speaking in a baby voice. Stuttering had begun the past 8 months, though her speech had been formerly intact. Speech therapy had been unsuccessful, as Shira had refused to cooperate.

Shira was described by her preschool teacher as social, though with a tendency to dominate friends. At times she would appear to daydream, especially in group situations, and often gave others the impression she was ignoring them. She seemed inattentive, had difficulty with structure and with focusing on one activity and was highly distractible with a rather short attention span.

Shira had been recently evaluated by a developmental psychologist with difficulties in concentration, attentiveness and in abstract thinking. Her cognitive functioning was otherwise normal. She was further diagnosed as anxious and dependent with poor coping skills.

The therapy's main goal was to support and assist Shira in coping with her mother's upcoming surgical procedure, subsequent absence from the home and impaired functioning. Her parents' goals further included toning down Shira's excessively loud, shouting speech, expressing her turbulent emotions through acceptable outlets such as singing, improving her ability to verbally express herself and regulating her impulsive behavior and emotional outbursts.

Process.

Stage 1: The emerging voice (sessions 1-4). Shira, a well-groomed, playful and alert child, first arrives at the clinic accompanied by her mother. She originally hides her head in her mother's skirt and refuses to enter without her, holding onto her so tightly her mother can barely move. However, following an initial welcome song, she soon allows her mother to wait for her outside the room. Shira speaks in a very loud voice, bordering on yelling, babbling excitedly at a fast tempo about things she sees in the room and has done in the past, stuttering throughout. Her voice becomes louder yet when background music is played.

She explores the clinic thoroughly, opening drawers, searching for yet more instruments in the closets, climbing on chairs to check higher areas. She attempts to do many things one after another, however many of her ideas are not well-developed. It is of importance to her to figure out everything by herself, "alone", blatantly refusing any assistance. She furthermore attempts to "teach me" how to play the instruments in the clinic. She tends to dictate most of the course of these first sessions. Any direction on my part is immediately met with a loud "No!" followed by suggestions of her own. Shira doesn't always appear to listen when spoken to. Her demeanor is restless though cheerful, usually presenting with a large smile on her face.

The instrumental sounds Shira plays are loud, sudden, surprising sounds, at times accompanied by complementary voices. She plays whistles loudly, hanging them around her

neck for entire sessions, and plays wildly on the drum set with a loud, fast, disorganized rhythm while laughing loudly. She often requests to play on whatever instrument I'm playing, even if she is already playing on an identical one. This is true especially in regards to wind instruments. She is seemingly most interested in drawing cheerful pictures on the whiteboard (e.g. flowers, sun, blue skies…) to uplifting background music.

I begin adding a vocal element to the sessions by vocally improvising to Shira's drawing strokes and to the free dance movements she performs with scarves. She initially reacts to this by smiling and by varying her movements and by scribbling. She eventually suggests we switch roles and begins to vocalize to my movements and sketches, albeit very loudly.

When I hand her the microphone, she begins vocalizing freely into it with loud staccato shouts, frightening voices and laughter while adding the clashing of cymbals to these vocalizations. She then requests I do the same. I turn my free vocalization into a mutual one, passing the microphone between us. Shira turns our subsequent mutual vocalizations into familiar tunes, all of them loud and rhythmic. She avoids touching upon softer or more gentle voices. She does however become more attentive through singing together.

Shira avoids touching upon emotions during these sessions, and her speech reveals no emotional content. It is difficult to understand her due to her accelerated rate of speech, stuttering and at times halting speech.

Shira begins planning the subsequent session at end of the previous one and makes a habit of demonstrating her instrument playing to her mother at the end of sessions. She has a difficult time finishing these sessions and often refuses to leave the room when it's time to end.

Stage 2: Volume games (sessions 4-7). At this time, Shira becomes enthralled with an audio recording program in the clinic which visually indicates the volume of her voice on a screen. Through this, she grasps the fact that her voice is quite loud and begins to make some attempts to lower the volume of her voice, checking though the program if she is indeed

successful in doing so. I continue this line of newfound interest through volume games which include singing the quietest we can, improvising freely on vocal volume graphs we create for each other and joining in singing along to familiar songs while varying our vocal volume to suit the changing volume the song is played at. Shira succeeds nicely in all these, seems to enjoy varying her vocal volumes and through this experiences different volumes and qualities to her voice. Nevertheless, when she sees her mother at the end of the session she begins shouting once again and very loudly demonstrates her instrument playing for her.

Stage 3: Structuring speech (sessions 5-8). In order to assist in structuring Shira's speech and to raise awareness to its accelerated tempo, we conduct conversations while drumming according to the syllables of our words. This requires her to decelerate her tempo of speech and seems to moderate her stuttering throughout the intervention. I then demonstrate a simple rhythm and we play it continually on darbukas at a medium speaking tempo. To this we add conversational speech. Shira tends to accelerate any given tempo, even when she is encouraged to originally set the tempo according to how fast she thinks her speech should be. Nonetheless, this intervention aids in regulating Shira's speaking tempo for the remainder of the session and appears to somewhat slow down her general tempo of rushing from one thing to another in the room. I begin to incorporate rhythmic speech interventions at the beginning of the following sessions and whenever her stuttering arises.

We further stress the calming and structuring benefits of the rhythmic component through vocalizations to free, disorganized movements vs. more structured, rhythmic movements. I additionally introduce mutual rhythmic vocal improvisations in which I improvise a basic accompanying vocal rhythm which Shira vocalizes above. We initially add rhythmic instrumental accompaniment to these vocal improvisations, however the instrumental addition later becomes unnecessary.

Slower, calmer breathing was encouraged at this time through playful breath exercises to promote relaxation and to aid in further regulating tempo of speech. This proved especially helpful at the beginning of sessions.

Shira now began to gradually speak in the therapy setting in a more mellow voice with less "attack" and pressure and at a more moderate tempo, which significantly aided with her stuttering.

Stage 4: Melancholic melodies (sessions 6-10). Shira now participates in turn-taking improvisations of a varied vocal nature, continuing melodies I prompt with a correlating melody of her own. She additionally begins to initiate such improvisations herself. Improvised vocalizations on different emotions ensue and we begin integrating more melancholic melodies. These are inspired by pictures she would spontaneously draw, such as a gloomy, rainy day and by singing to a tearful doll. However, these melancholic melodies would transform into cheerful ones as the improvisation continued. I adopted a supportive, containing vocal role throughout future improvisations. This appeared to aid her in remaining longer with improvisations of a calmer and more solemn nature.

Lengthy, spontaneous conversations were now carried out through singsong speech, thus combining singing with verbal expression while incorporating vocal fluency qualities into her speech. Shira cooperated well with this, claiming it was "fun" to talk in this manner. During these melodic conversations, Shira's voice would incorporate the flowing, fluent quality of singing and her words could be clearly understood. By the end of this stage, no stuttering could be detected in her speech. She now remained far longer with each intervention and appeared more relaxed and focused.

Stage 5: Singing fears (sessions 8-12). Shira's mother was now to undergo her operation and Shira arrives at therapy accompanied by a babysitter for the first time. Though she seems rather jubilant and bubbly, her vocal improvisations reveal otherwise. Throughout many of

these following sessions she is disorganized, restless and distractible. She also begins some of these sessions reverting to her previous loud, shouting voice. Her father reveals she told him that if he didn't give her something she wanted she would: "…go to the hospital and die there".

Alongside familiar songs, we dedicate improvised vocalizations varying in emotion to her mother: Sad, frightful, hopeful and joyful. Shira chooses accompanying instruments accordingly, beginning with "happy". Lyrics were then added to emotional vocalizations and they began to take on a conversational nature. Among the themes that now arose through these mutual verbal improvisations: The hospital, her mother's surgery and the gradual recuperation that awaited her mother. Many fears and grave misconceptions were expressed through these vocal improvisations:

> "…it happens to mothers, that they hurt, their tummy hurts. They need to cut open their stomach and they're sick…". (apparently associating motherhood with pain and surgery).
>
> "…they cut mommy's stomach in half and then put tubes in her. I saw them... I saw the tubes, I saw them do that to her!"
>
> "Mommy came back from the hospital but her tummy is not closed yet…her tummy is open…".

Shira repeatedly made reference through song to her mother's stomach still being open for several sessions, weeks following her mother's release from the hospital, and was apparently referring to the scar on her mother's stomach.

The conversational format of these improvisations allowed me to calm her fears through soothing melody, reflect lyrically and melodically on her expression as well as verbally reassure her and clarify her misunderstandings regarding her mother's situation.

Shira enjoyed subsequently listening to recordings of these improvisations. She would listen attentively to my lyric contributions in them, at times commenting: "Yes, that's true, that's right…".

These vocal improvisations on her mother's situation commenced with a song entitled: "Mommy is no longer sick". During this stage, Shira began to "accidentally" leave personal items such as bracelets in the therapy room.

Stage 6: Talking fears (sessions 11-14). Shira now begins to verbally express her fears in therapy without the aid of song. Many changes await her that she doesn't seem to fully grasp: With summer vacation approaching her preschool is ending, she's soon to begin summer camp and the end of our therapy sessions is near. Shira is seemingly unaware she'll be attending a new preschool with a new teacher and different friends the upcoming school year. I relay this significant information to her gradually and rather delicately by incorporating it into improvised songs I sing to her. It appeared she could better process, understand and accept this information (both cognitively and emotionally) when relayed to her in this manner. She appeared to listen intently to these songs, later posing questions pertaining to certain lyrics. While processing these matters, Shira verbally articulated her anxieties surrounding losing people in her life and disclosed there were people who "were taken" from her: Her grandfather who passed away and friends who moved away. She fears she'll never see her preschool friends again and reveals a fantasy of bringing a friend of hers home and "never letting her leave".

Stage 7: Vocal summarization (sessions 13-15). Shira appears to now better understand the changes that await her and in some respects looks forward to beginning her new preschool. We summarize our time together, the memories that will remain with her and some of the feelings surrounding saying goodbye through mutual vocal improvisations. Her vocal qualities now far more accurately reflect the emotions communicated in her lyrics. Shira claims she's never actually said goodbye to anyone before. She requests to revisit vocal improvisations

recorded throughout the therapy. We review through them how her voice transitioned throughout the process from painfully loud at times to mostly pleasant and tender. We improvise a song about this "new", more genuine and emotionally integrated voice of hers, sung with the qualities she attributes to it: Nice, gentle, "not nervous", "sometimes sad". She receives an audio disc which includes some of the songs we recorded together. Shira parts from her favorite instrument in the room, the microphone, with the clear and confident singing of a goodbye song.

Parental update. Shira's parents update that her voice has lowered in volume and has mostly lost its previous shouting quality. She now often sings softly to herself while playing in the home. She has begun to tell her mother she no longer wants to "be a baby", no longer reverts to speaking in a baby voice and has ceased to wet the bed at night. Her parents further comment on her improved listening skills and memory and sense she is overall far calmer and focused than before. Her stuttering has improved considerably and is now barely detectable, except for when she fights with her sibling.

Case Study 2.

Background. Noa, a boisterous 8 year old girl, was referred to music therapy by her parents. She was born an only child to very elderly parents, both in mental health professions. Small in build and short in stature, Noa looked younger than her age and was held back in kindergarten for an additional year due to maturity issues. She was described by her parents as a creative, imaginative, intelligent, very energetic and musical child who loved to dance and to sing. However, she had difficulty with boundaries and with accepting direction at school and at home, would throw screaming temper tantrums (even in public areas) and strike her mother. She had a low frustration threshold and a tendency to throw food and to and break objects when she didn't succeed or get her way at home or alternatively, to hit herself. She wouldn't express emotions at home, speak of school or express any grievances. Noa attended an ultra-Orthodox school where she experienced social difficulties with classmates, had a tendency to be envious of friends, would steal from them and tell lies. She was inclined to be dominated in friendships and would befriend older girls who were controlling and protective of her. She was often scolded and punished in school for unruly behavior.

Additionally, Noa presented with an array of fears including loud noises, hail and monsters. Many difficulties also surrounded her bedtime: She had difficulty falling asleep at night, would suck her thumb, suffered from nightmares and wore a diaper to bed since she would wet the bed at night. One of her most prominent symptoms was a complex motor and vocal tic in which she would at times stick out her tongue and blurt out the word "stupid" to no one in particular.

Noa had been treated by an educational psychologist at her school and had undergone various creative and expressive therapies with no perceived improvement by her parents.

The initial goals set for Noa's therapy were: Emotional expression and regulation, improvement of sleeping difficulties, acceptance of boundaries, improved self-image and confidence. Her parents also expressed a desire for Noa to be able to be more independent.

Process. Stages of therapy generally overlapped, usually with components from one stage being present in others, often occurring concurrently throughout the therapeutic process. This rough division into stages mostly signifies the emphasis put on specific issues during certain phases of the therapy process.

Stage 1: Vocal togetherness (sessions 1-5). Excited when she sees the musical instruments in the clinic, Noa immediately rushes to the piano and improvises a jubilant melody, forgoing greeting or even initially acknowledging my presence. This pattern continues for the first few sessions. When I play a greeting song for her, she joins in on piano, but quickly changes the rhythm of the song, accelerating it and making it more staccato. She brings a recorder from home to "show me" how she plays, but simply blows loudly into without bothering with fingering. Her voice expresses excitation but much nervousness as well, with a recurring tremolo. Noa mainly dictates the direction of the therapy during these first sessions, initiating musical games during which she controls my movement through her playing. She quickly tries out many instruments, one after the other, searching for ones unfamiliar to her, returning a couple of times to the drum set, playing on it freely after initially fearing breaking it should she play loudly. Noa also shows a special interest in wind instruments. An improvised storyline emerges through her playing on the drum set during this stage about a monster that emerges from a storm and devours people. She repeatedly instructs me to hide from the monster.

Noa soon approaches the microphone and sings loudly. Her voice playfully sways between quite beautiful, aesthetic singing on high notes and a sudden low, rather sinister voice an octave lower. Interventions which promote vocal togetherness follow, to which Noa

responds with increased focus on our mutual interaction. These gives way to improvising stories through song while passing the microphone between us. Her first improvisation is about a girl who sings and plays music and is applauded and praised for doing so. She soon continues with storytelling songs on the topic of friends, titling one "Debbie and the wolf" (she later admits she is the "Debbie" in the song).

Noa refuses to permit any verbal conversation during this stage. In expressive vocal games, the only emotions she freely expresses are positive "happy" ones. She actively avoids conveying emotions with more negative connotations, such as sad, angry and frightened. However, Noa always expresses disappointment when the session ends.

Stage 2: Emotional voices (sessions 5-10.) Noa gradually becomes more willing to touch upon emotions in therapy. She progresses to kazoo dialogues with me on a variety of emotions and explores her emotional vocal range through mutual gibberish conversations with me as well. She now agrees to sing songs of a more melancholic nature and accepts direction finding a suiting voice for this newly expressed emotion. Storytelling songs of a sadder nature begin to emerge which tell of a girl who's miserable because nobody at school will play with her. She elaborates that the girl was called "stinky, annoying and stupid". Following this, she begins vocalizing on "natural sounds" attributed to her story characters, such as those of crying and of growling.

Plays during which Noa expresses her emotions though animal sounds also begin to appear. In such a one she's a kitten who's lost her mother: The kitten is frightened of thieves and of noises and the mother cat (which we both play, at times alternating roles) feeds her, calms and protects her and sings her a calming song. Throughout, Noa communicates as a kitten through a variety of emotionally expressive meows according to the situation presented and the emotion provoked through the play.

It is during this stage of diverse emotional expression that Noa's tics make their debut in therapy: She now begins to stick out her tongue from time to time and blurts out the word "stupid!" This first appears when she begins to play "teacher", writing on the whiteboard. Whenever she would make a spelling error, even the minutest one, she would suddenly utter "stupid!" She then continued to blurt out the insult even before she began writing, and then seemingly randomly for no apparent reason in a variety of situations, even those associated with successes. I would attempt to reflect the possible feelings behind these tics through improvised songs.

Stage 3: Confronting fears (8-15). Noa was now ready to begin confronting her fears in therapy. We put on plays during which we chase away "shadows of darkness" and monster puppets in the dark with loud drumming and yelling and improvise "fear" songs on hail, darkness and monsters. She begins adding to our vocal improvisations additional frightening experiences, such as nobody being home once when she arrived from school. She also expresses deep-seated anxieties through storytelling songs which tell of her parents being killed by a monster and being left alone and needing a new family with a strong father to protect her from the monster. Noa slowly begins to reveal her fears concerning her parents dying, disclosing through song dialogue that they both were at the hospital and take medications. This leads to a conversation of her parents being elderly and of her not having any family besides them. Though when fears were originally raised Noa would begin sticking her tongue out, it was observed that following interventions, tics that were present at the beginning of sessions ceased to appear for the remainder of the session. This work was interspersed with vocal interactions and activities that promoted positive experiences of success.

Throughout this stage, Noa would attempt to frighten me with a loud "Boo!" upon entering the clinic and would at times hide from her father and jump out to surprise him when he picked her up from the session. She also began to rock the chair she stood on when she

erased the whiteboard, creating a situation in which I had to catch her or hold onto her to keep her from falling. By the end of this stage, Noa would touch upon fear with increased ease. She still experienced difficulty ending the sessions and required firm boundaries be set on this matter time and again.

Stage 4: Embracing anger (10-15). Noa now plays all instruments in sight with all her strength, claiming they are all "nervous". It is now possible to engage her with playful argumentative conversations and yelling through the kazoo, which she does while accompanying herself with loud playing on the gathering drum. When "anger songs" are sung to her she responds with wild dancing, jumping and loud drum playing, agreeing to add yells of "ahhhh!" while doing so. She now becomes interested in interventions tailored to give voice to feelings of anger and gradually begins to verbally express situations that bother or anger her through interventions that promote yelling and later through unprompted conventional speech. Her grievances include other children not wanting to play with her, being called stupid, being cursed at, being yelled at by teachers, not succeeding, having others being angry with her and hitting her.

During this stage, Noa's various tics became confined to the beginning of sessions alone. She began tidying the room up after herself at the end of sessions, and became very affectionate towards me, embracing and expressing positive sentiment towards me before leaving. Her favorite instrument became the microphone, and through it she would now yell orders and sing songs in a loud, angry voice.

Stage 5: Lullabying (sessions 15-18). Noa's father informs me she has difficulty falling asleep at night and suffers from recurring nightmares. She frequently calls out to her parents throughout the night, often in a crying fit, and crawls into their bed to sleep with them.

We now add soothing vocal elements to the sessions, such as more fluent singing, vocalizations requiring deeper breathing and more subtle, calming vocal improvisations to

which we sometimes accompany ourselves on small harps. We continue by touching on sleep issues in a more straightforward manner: While Noa spontaneously improvises on the synthesizer, I begin vocally improvising a calming goodnight song, leaving spaces for her to join in and contribute to the lyrics. She continues by improvising such a song on her own to my musical accompaniment, asking G-d to protect her from all the things she fears. These include animals devouring her, being killed, beaten and others sticking their tongue out at her. At her request, we record this song and transfer it to a disc so she may listen to it before bedtime. She entitles it "fear and the night" and later claims it helps her fall asleep.

Noa's mother updates me that she feels Noa has now progressed. She reports that the audio disc was effective in aiding with Noa's sleep issues and that she listens to it regularly before bedtime. She now falls asleep while listening to relaxing music and only sleeps in her parent's bed on the Sabbath when playing music on electronic devices is forbidden. Additionally, she claims Noa now communicates and expresses herself better at home and credits the therapy in realizing this goal. She additionally reports that Noa did not exhibit any tics during a lengthy holiday vacation until they mentioned returning to school.

Stage 6: The split voice (16-20). Noa now initiates dividing instruments into groups of delicate or angry instruments upon entering the room. Her requests to "play teacher" for part of the sessions are ongoing and develop into plays in which she play a "good teacher", grading children's' behavior by placing happy or sad faces near their names. She places happy faces near our names and sad faces near other children's names, including names that very closely resemble hers and mine, claiming they were "bad". As teacher, Noa also begins criticizing me and demanding corrections on things she requests I do. When as pupil I express any difficulty complying with her demands, she responds by telling me I must "overcome my evil inclination".

Noa's vocal improvisations now become increasingly personal. She sings about herself being well behaved, always doing good, being sweet and cute and "never lying". This leads to a singsong discussion between us on how she views allowing herself to also sometimes be mischievous, angry and make mistakes. We sing about the different aspects of her behavior and Noa now begins to describe herself as "naughty at times" and mentions her personal "evil inclination". Shortly following her recognition of her more unconstructive traits, her tics recommence for that particular session. We continue by exploring the voices she attributes this side of herself she views as negative, as well as the voices of the parts she views as positive. She moves to and fro between these voices she views as opposing during this intervention as well as spontaneously throughout following sessions. During this stage, Noa required more reassurance than ever that she was still valued and worthy of affection, often inquiring at the end of sessions what I felt for her.

Concurrently, I received word from Noa's parents that they had made a decision to transfer her to another school, since her current one was intolerant of her behavior. They viewed her teacher's treatment of her as cold, scolding and rejecting. However, Noa wouldn't cooperate with the entrance exams required by the schools they were considering. Her parents believed she was deliberately attempting to hamper their attempts to get her transferred. She expressed a strong objection to the proposed change, claiming she loved her teacher and didn't want to leave her.

Stage 7: Vocal Integration (19-25). We eventually work towards an integration of the abovementioned voices and towards being able to attribute both of them to a stable, readjusted image of herself. The aim was to enable Noa to accept this new concept of herself as a girl with a multi-faceted, but overall positive and valued personality.

I sing improvised songs I dedicate to different aspects in her: Noa the frightened, sad, loving, happy, nervous, and angry. Noa joins in on the trumpet and dances. She soon begins

sessions by declaring she is "angry Noa" today, subsequently improvising songs on the day's events leading up to her sentiment. She also begins to request I play different types of music on various instruments (delicate, angry, calm, happy, sad), while she joins in by improvising vocally on the microphone. She dedicates improvised songs to me on love and requests I dedicate songs specifically to "the beautiful and sweet Noa". Ultimately, songs integrating the multi-faceted aspects of her personality are composed and sung for her. Noa responds by implementing this theme in her own vocal improvisations. She continues to seek assurance from me that she is accepted as she is with all these different aspects of her personality.

Her storytelling songs are still abundant with motifs of good and evil which is also reflected in the character voices she employs in plays. However, she begins to take a special interest in songs I integrate into the sessions which tell of virtuous princesses who are at times mischievous or make mistakes. Although she refuses to directly participate in the development and acting out of such storylines, she listens intently to them. In her musical plays, we alternate roles playing a monster with accompanying scary monster voices. However, the monsters in her plays now end up befriending and even protecting the princess.

Stage 8: A final song (23 -25). Noa's tics are no longer present in therapy and her parents confirm they no longer appear at home either. She falls asleep with increased ease and her sleep is now far sounder than before. She no longer wets the bed and remains in her own bedroom throughout the night. Behavioral issues still exist in the home, but have decreased in severity and are more manageable for her parents. Noa now expresses difficult feelings far more freely and with increased ease. She has ceased mentioning monsters. At this time, Noa's parents decide to terminate treatment due to technical difficulties that prevent them from continuing.

Noa avoids the topic of saying goodbye directly in therapy, but expresses her feelings on the topic through amplified vocal volume and increasingly agitated playing, admitting to her emotions of anger. She improvises a gibberish conversation with me, including many

diverse emotions while singing at the top of her voice and drumming strongly and loudly. Her powerful playing causes her to unintentionally break a darbuka in the room.

We sing about the new school she'll be going to next year, including her fears and hopes associated with the change. She suggests she'll have many new friends there. Noa requests to take many things from the clinic home with her. However, she makes due with recordings of therapeutic songs she sung regarding self-image and the opposing parts within herself. She claims she'll play them in the car, at home and before bedtime, as she did with the previous disc. She writes a title on the audio disc: "I am me?" (with a question mark at the end). We work together to try to turn the question mark into an exclamation mark!

I sing a final goodbye to all the different aspects of Noa. She joins in, suggesting herself some of these aspects while she playfully acts them out with appropriate facial expressions, body language and vocalizations. Among those she offers: Loving, angry, sweet, mischievous, annoying, goodhearted and "monster" Noa. I assure her all these parts of her are accepted and loved.

Case study 3.

Background. Leah was referred to music therapy at the age of 5.5 by a developmental psychologist half a year after being diagnosed with selective mutism. She was born following a normal pregnancy and birth to a warm, caring family with no close history of anxiety or mental health disorders. Her motor development, hearing, intelligence, speech and language development all remained intact throughout her growth. Her fear of speaking with adults began at age 3 upon entering preschool, and besides strangers, included her preschool teacher and any family member outside her immediate family. According to the referring psychologist, she had refused to fully cooperate in her psychological diagnosis, nearly bursting out in tears in certain sections. She had displayed much resistance in tasks requiring verbal expression, had difficulty expressing emotions and had presented with a low frustration threshold.

Leah's preschool teacher described her as closed, shy, stubborn, passive with low self-esteem, preferring to play alone. She would communicate with her teacher mostly through hand gestures, refuse to cooperate in group activities and would not initiate contact with other children, though she would speak individually with select children, especially those younger than her. She was careful to evade any activity that included noise, and would avoid physical contact and close proximity to all children. At times, she would prefer to soil herself rather than ask permission from the teacher to use the restroom.

Leah's parents described her as bright, stubborn, physically rigid, communicative and very talkative in the home. She was perceived as a "good girl" and had an exceptionally close relationship to her mother and positive relationships with her two siblings. She had difficulty with confrontation and would often seek a sense of control. She would become highly dependent on her parents and often freeze in social situations, refusing to even speak with her mother in the presence of others. At times she would speak at home in a baby voice. She had no prior experience playing musical instruments, but enjoyed singing children's songs at home.

Process. Stages of therapy generally overlapped, usually with components from one stage being present in others, often occurring concurrently throughout the therapeutic process. This rough division into stages mostly signifies the emphasis put on specific issues during certain phases of the therapy process.

Stage 1: Pre-vocal: Speaking through music (sessions 1-4). Leah is initially hesitant upon entering the music and voice therapy clinic, clinging and pulling at her mother, signaling to her she doesn't want to enter. She agrees to come in only with her mother by her side. Initially, she refuses to even touch the musical instruments in the room. Following her mother's participation in a musical interaction with me, she begins to join in as well on small percussion instruments, so long as the interaction is structured and her mother continues to be involved in the music making. The minute the musical intervention becomes less structured, Leah suddenly ceases to play and freezes. She does not speak or make any vocal sounds throughout the first few sessions. Her mother begins leaving the room half-way through the following sessions, assuring her she will be close by and will soon return. I soon introduce various wind instruments, beginning with relatively straightforward ones of moderate volume she seemed to show an interest in. Musical conversations ensue among our selected instruments, often turning into a mock argument. I then introduce her to louder and larger wind instruments and encourage her to explore them. Following the playful introduction of the kazoo, Leah incorporates it in musical interactions and begins joining in on it, joyfully "singing" along through it during the "goodbye song" I sing for her. Immediately following this, she initiates her first word in the therapy room: "Goodbye".

Subsequently, she enters the therapy room without her mother and begins to speak single words occasionally throughout the following sessions, as well as sometimes speak with her mother in my presence. By session no. 4 she begins to at times speak more words, forming

short sentences, but only when I divert my gaze from her. She continues to play the kazoo, but abruptly stops whenever I attempt to engage her in familiar songs or in improvised melodies.

Stage 2: Releasing the voice (sessions 3-14). Various playful interventions, mostly structured, are incorporated into the following sessions to aid in easing Leah's vocal tension and to support her vocal release. Movement, sighing and breath exploration and control exercises are introduced to reduce her physical rigidity and anxiety. The kazoo is frequently integrated into the sessions to allow her to become accustomed to using her vocal chords freely (while still allowing her to mask her vocality). Once Leah is prepared to release her voice through sound without the assistance of the kazoo, natural sounds, animal sounds and simple syllables are encouraged through interactive play, usually while incorporating props. Special attention is given to helping her unfreeze her voice in moments of fear and in anxiety provoking situations while incorporating movement and loud instrument playing.

Actual singing is initially promoted through structured nonsense songs which require only vocal imitation, mostly of sounds and of syllables. Her voice remains rather low in volume at this stage and at times barely audible when speaking in the therapy room, however she begins to incorporate the microphone at times while singing parts of simple songs. She initially agrees to my audio recording her instrument playing, but takes longer to feel comfortable with recording her voice. She would request to save these audio recordings and enjoy listening to them afterwards and in following sessions. During this stage, Leah began bringing drawings she prepared at home to the sessions and would present them to me: In them she would be standing between me and her mother or between me and her home, and we would always be holding hands.

Leah's mother reported she had begun to laugh out loud and even make some animal sounds in kindergarten when prompted. She had also begun vocally communicating more with other children.

Stage 3: Vocal augmentation (sessions 13-23). Work on musical dynamics through instruments and afterwards through the voice characterizes this stage. This leads the path to Leah expressing and working towards overcoming her fears through sounds, once again initially through instruments and then transferred to vocal work. This direction incorporates much confrontational play. Though she would play especially loudly and freely on wind instruments (perhaps compensating for her lack of vocal release) and incorporate more natural sounds, Leah's voice would still vary in dynamics from session to session and from intervention to intervention. She would at times whisper through songs or suddenly falls silent within the session. Limiting her vocal role and the words she sang in songs contributed toward gaining her cooperation. A small regression took place in Leah's progression following a lengthy holiday vacation. She returned to insisting on her mother's presence throughout parts of these sessions, especially upon entering the therapy room. However, this regression was soon overcome, and it became possible to gain Leah's explicit consent to try to work together on making her voice more audible. Following this, Leah began to laugh spontaneously during the sessions (sometimes even seemingly uncontrollably). She would answer straightforward questions immediately and in full sentences while making eye contact, albeit hesitantly in a whisper with her head lowered. She would not respond to open-ended questions to which there was no "correct" answer. She only initiated questions herself through the use of the kazoo. Her speaking voice was mostly clear and in medium volume, though quite monotonic. She continued to fall silent at times or seemingly "freeze" when she was uncertain of the correctness of her response. Though she began to choose new and challenging instruments to explore when prompted, she would still hesitate before choosing them and would not express her wishes in the room. Leah required much legitimization of all her vocal attempts throughout this stage.

Following this stage, Leah's parents informed me she had begun standing up for herself in kindergarten and was now speaking with friends in regular speaking voice volume. She had

also begun answering her kindergarten teacher with short one-word answers. In her end of year kindergarten party, she performed in a group dance before an audience for first time and even had a short speaking role which she presented alongside another child. Still, she continued to cling to her parents in the presence of strangers and refused to initiate contact of any kind with anyone outside of her immediate family.

Stage 4: Vocal Initiation (sessions 18-29). Interventions regarding conversational abilities characterize this stage. This is realized first though instruments, then through gibberish and song, gradually working up to direct speech. Leah now responds without hesitation even to complex questions when directed at her through song, instead of falling silent and answers "I don't know" when uncertain (instead of falling silent), even without prompting. She also begins to initiate choosing instruments, and does so without hesitation. She initiates joining in singing with the opening "hello song" and begins to call me by name in the sessions. Leah's contributions in vocal interventions, even when posing questions, begin to turn from imitations to true instigations. This allows for more unstructured vocal interventions, including free vocal improvisations. Leah still exhibits difficulty when choosing songs to sing, with making eye contact at times and in expressing personal needs and desires in therapy, especially saying "no".

Leah begins first grade speaking to the school children but not to the teacher. She soon begins speaking shortly with the teacher as well, raises her hand and provides one-word responses in class.

Stage 5: Voicing fears (sessions 28-38). Leah now begins to express her fears of an angry response from people she may speak with, including hitting and "roaring". She recalls such incidences in the past, including being beaten by a group of boys at kindergarten at the age of 5. Her response then was to cry and to otherwise remain silent and passive. Following her drawing a picture of the incident which she entitled "bad memory", we focus on enabling her to defend herself vocally and being able to depend on her voice to be there for her when

she needs it. A short period of regression during which her voice once again becomes barely inaudible follows the beginning of this work. Throughout the process, whenever Leah ceases to speak or to participate with vocal interventions in therapy, she continues to actively partake in therapy and to interact through instrument playing. Through this, she begins to loosen up physically, reinforcing her positive experiences in therapy enough to once again feel comfortable enough to return to her former level of vocal involvement. Listening to her vocal audio recordings also helps regain her participation. Her regression eventually paves the way to increasing disclosures of her fearful emotions and sensations, such as feeling "frozen" when she's afraid. Towards the end of this stage, she begins initiating activities in therapy and reveals that she is now only "a little frightened of speaking", not "a lot" as before. She shares her continued fear of speaking before the class and with the teacher and begins to attempt to do so more despite her difficulty. Her willingness to audio record vocal interventions still varies from session to session.

Stage 6: Vocal relaxation (sessions 38-43). Following vocal emotion interventions, Leah shares her difficulty in feeling calm in general. We extend work on deep breathing and on releasing vocal tension, encouraged through play.

Leah now begins to initiate spontaneous singing in therapy. She responds to questions quickly and with ease, with a natural sounding, louder voice. Leah herself informs me that she now often speaks in front of the entire class, though her fear of speaking to strangers remains. Her teacher adds that she is social, laughs and answers questions in class, shares experiences, physically embraces some of her teachers and that her struggles concerning speech are barely sensed.

Stage 7: Talkative vs. shyness (sessions 41-50). Playful vocal interventions lead to Leah's expression of her desire to be talkative instead of shy and her belief that she possesses such a side to her personality. Our work focuses on encouraging and giving voice to this aspect

of hers and to its unique qualities, while continuing to battle against her tendency to bashfulness. Interventions of "battling shyness" are now ongoing and are used as warm-ups or as needed whenever she falls silent. During this stage, she writes her first song in therapy (with the aid of the therapist): "Come talkativeness". Towards the end of this stage, Leah announces at the beginning of a session that "talkative Leah" has come to visit. When I ask her what happened to her shyness, she responds that her shyness "got lost". Following this, her mother updates that Leah participated in a school celebration in which she sang in a choir participated in a group dance on stage before an audience of 400 spectators. She told her mother before going on stage that if there were any problems she would "chase the shyness away" as she was taught in therapy, but didn't end up needing to. Her homeroom teacher reported she now often chats with her schoolmates during class, at times even disrupting the class while doing so.

Leah now freely and joyfully initiates sharing her experiences in therapy. In vocal interventions, she at times still has an initial difficulty in beginning to sound her voice, but after overcoming it she participates fully vocally. Her claim of: "I don't know how" when a suggestion in made to her still occasionally arises, but is quickly overcome. Though she claims "the shyness" still visits her from time to time, she speaks far more at length, telling stories of things she did over the holidays. She now speaks freely in full sentences in therapy, often joining in singing freely on her own initiative. Leah's birthday wish was to be able to "speak with everyone".

Stage 8: Emotional voices (sessions 51-68). Leah reveals to me that she speaks with nearly everyone at school except with a specific teacher she finds intimidating because she yelled at her in class. Her mother adds that she responds with much fear and anguish whenever a teacher raises their voice at her or yells at the class, and immediately bursts out in tears whenever her parents scold her.

Her pattern of regressing following a very successful session continues. Likewise, when she hits vocal dynamic peaks she often suddenly falls silent as though frightened by her own vocal strength. She is unable to explain why this happens, but seemingly associates it with anger.

Many fears concerning sounds emerge during this stage: Loud noises, ram's horn (shofar) blowing in the synagogue, yelling, loud voices, angry voices, animal sounds like roars. Leah also conveyed an overwhelming fear of anything considered physically intrusive such as needles (especially vaccinations), of all doctors and of ear piercing, often thinking of these at bedtime.

At this time, Leah's mother underwent surgery and became consequently depressed. Leah abruptly became distressed for a number of weeks, experienced unexplainable bouts of crying and stopped speaking to teachers and participating in class. In therapy, she refused to touch upon the emotion of sadness, and when we discussed her feelings in regard to those of her mother, she could barely contain her upset.

These incidences led to working on vocal expression of strong emotions she had difficulty accepting in others and in herself, such as anger, fear and sadness. The goal was to enable her to not only express these emotions vocally, but learn to accept, develop and embody within herself the very voices she feared and rejected. This approach led to the cultivating of the many divergent voices within her, including among others the "huge voice", "angry voice", "scared voice" and "scary voice". These voices were discovered and developed through playful voice work with different "vocal ingredients" (Paul Newham, 1999), mainly loudness, pitch, attack and free air.

Consequently, Leah began to contribute more to our beginning emotion-check song as far as experiences she found sad, annoying or frightening. Her answers to my queries would be immediate and lengthy and she would explain and elaborate on them as she felt necessary. She

managed to reach vocal heights dynamically without becoming frightened and stopping abruptly as before, and would even attempt to repeat the loudest part of her vocal production afterwards. When Leah begun summer camp with children unfamiliar to her, she spoke to them all. Still, she wouldn't initiate conversations with adults outside the immediate family, and at school would only contact teachers when needed through a family member who attended her school.

Stage 9: The angry voice (sessions 69-85). Leah now speaks openly of emotions and begins mentioning actual situations that anger her for the first time, beginning with anger towards friends in certain situations and later towards specific teachers. Her anger is directed towards teachers who raise their voice in class, yelling not specifically at her but towards any child who would enter the class tardy. Apparently, what bothered her was no longer the volume of the teacher's augmented voice (which she demonstrated on a trumpet), but rather the perceived emotion of anger present in the yelling. Leah explained that yelling indicated anger and that can anger could lead to physical violence, mainly hitting. It appeared then that the source of her fear was the possibility of the physical violence inherent in anger. She had borne witness to such occurrences in the schoolyard. She was now able to express her personal feelings of anger through vocal interventions and through these began to recognize and confront her fear of her own anger. These included composing an "anger song" of the many things that angered her, including teachers, other children, friends, siblings, parents. Touching upon her anger towards her parents was especially challenging for her, with her initially denying any negative feelings towards them, but soon dedicating many lines to expressing her rather typical anger towards them in her song. This was performed and audio recorded in the "angry voice" she had discovered and developed in the room and now allowed herself to access and give voice to. Legitimization was key throughout this process. She then requested to transfer the song to a disc to take home and play for her parents: "…so they'll know I'm angry!"

Throughout this stage, Leah progressed in many realms: She began asserting herself somewhat more, using the word "no" more often, even while responding to some of my suggestions in therapy, she began to speak with a teacher who frightened her, began calling family members on the phone and answered the phone when a stranger called, participated in a community singing event in which she sang loudly and spoke before her entire class and teacher on a topic as a class assignment. She informed me she felt no bashfulness at all doing so. Additionally, her mother had previously repeatedly reported on her extreme and overwhelming fear of injections and doctors which resulted in Leah refusing to cooperate with these. In therapy, Leah now began to express her fears concerning all invasive procedures, including vaccinations, blood tests, eye drops at the optometrist's office, dentist visits, etc. She claimed these procedures hurt and that she didn't feel "brave" enough to overcome her fears. Following progress of her general acceptance of her feelings of anger, she began to suggest that the emotion of anger could overcome that of fear since she felt anger was stronger. She proposed attempting to get angry at her fears since they disturbed her so much. This resulted in reports she would relay with much pride of her continued progress in tolerating somewhat more these invasive situations she found so intimidating.

Stage 10: Vocal image (sessions 71-81). We work on improving Leah's "vocal image", aiming to promote a confident voice and self-image regarding her voice. Listening to audio recordings of her newfound singing voice empowers her and becomes a source of enjoyment. She begins describing how she overcame shyness from week to week; Speaking with new people and in new situations, etc. When Leah recounts how she told a story in front of her class, she stresses with pride: "They listened to me!" She now claims that her shyness no longer "visits" her so much anymore, only when she must speak to a stranger or when she sings. She voices her new goal: "to speak with everyone all the time"!

Stage 11: Being heard (sessions 82-90). Leah claims to no longer be frightened of many things and explains how come very rationally. She still falls silent at times after raising her voice, but chats spontaneously during sessions. We discuss the divergent voices within her and when she uses them. Leah says she now uses her "loud voice" in school when someone takes her belongings and when she's not being listened to. She claims she has within her "all the voices", but would like for her "regular" everyday voice to be louder since she feels she's not heard enough. When listening back to an audio recording we made of her different voices, she claims she likes her "huge voice" the most, and though she would like to, she's ashamed to allow others to hear it. She now begins developing and practicing voicing her loud and "huge" voice more during the sessions alongside spontaneously investigating her many voices in the microphone. She eventually began to sound this newly developed voice of hers in school as well, answering questions in class in a clearly audible, confident voice and taking the stage to participate in a school quiz, though she "shook from fear" while doing so.

Stage 12: Vocal assertiveness (sessions 85-98). Leah still struggles to assert herself outside the home and has difficulty refusing to comply with suggestions from others, even in therapy. We now rehearse using her "huge" voice to assert her needs and emotions through the writing and recitation of a letter dedicated to a despised teacher, in presentation of an "I don't want to!" song and through vocal improvisations on things she desires to let friends know but fears to. Leah began accessing and sounding her "brave" voice.

Leah now began humming and giggling freely and without inhibitions throughout artistic interventions, and would investigate new instruments freely and on her own initiative. She would assert herself more in class, even yelling at the class "quiet!" when they were loud and rowdy. During this stage, Leah began to speak with strangers, answering their questions and making requests of waiters. She would speak in front of groups of children from other classes and with new teachers. Towards the end of this stage, she reported she now spoke with

whoever she chose to. She claimed that "shyness had already left her" because she "told it to" and assumed that it went to visit somebody else already.

Stage 13: Emotional impenetrability (sessions 97-105). Leah begins to speak of often being offended by others: When they point out her flaws (her being wrong), don't praise her enough, tease or provoke her. She's still overly sensitive to her mother's vocally expressed emotions (such as crying, even for positive reasons). Vocal work is done on stimulating such situations, on embodying and reacting to the perceived emotions of others. We then work together towards creating and a vocal "emotion shield" she may employ to protect herself from others' strong emotions and perceived "attacks".

Leah became more independent in a variety of situations outside the home and in therapy, often vocally improvising while alone and writing songs herself. She continued to assert herself in class, insisting friends call by her full name instead of the nick name as she was previously referred by. She spoke immediately to new children and teachers, creating fast friendships. At her end of year celebration she spoke on stage in front of other classes, parents and teachers and decided on her own initiative to give a speech at a large family celebration. Her mother reported she did so confidently and naturally.

Stage 14: Vocal farewell (sessions 106-110). Leah now speaks to everyone she meets, including strangers, in a large variety of social situations. Her fear of doctors and of injections is at a tolerable level and she no longer presents with any outstanding fears or anxieties. She vocalizes freely and independently in vocal improvisations and tends to initiate much more in general. With her mother's birth of twins, technical difficulties now arise pertaining to the therapy sessions. Following a parental summarization of Leah's progress, it is concluded that the therapy has realized all its goals and may now come to an end. Leah agrees on our account of her progress regarding her speech and fears, though she would prefer to continue attending

therapy nonetheless, going so far as to attempt to convince her mother to allow her come to me herself by bus.

Summarization took place through reviewing the artistic products of the process, including vocal recordings, while comparing Leah's voice at the beginning at throughout the therapy with its present state. She improvised vocally on the process she underwent in her quest to eventually be able to "speak with everyone", wrote a farewell song and improvised on it emotionally and vocally revisited all the divergent voices she had discovered within her. She concluded she had found her "strong voice" through the therapy process. When asked when she thought she'd use this newfound voice, she responded: "When I want to be heard, which is always!"

Case Analysis

As described in “analysis method”, recurring themes were found throughout the case studies reviewed. The emergences of these themes throughout the therapy sessions in each case studied were subsequently recorded on graphs. Varied uses of vocality emerged and labels were assigned to each vocal technique detected. These were later collected into more general groups termed "vocal elements", based on the similarities of the specific uses of vocality in each technique. The significance of these different forms of vocality and their unique contributions to the therapy process were examined through their visual recording in graphs. An individual graph detailing the emergences of the studied element throughout the therapy sessions was prepared for each case study. Element comparison gave rise to the categorization of vocal elements based on their incorporation of verbality and degree of vocal improvisation. Their emergence in different sections along the graph led to conclusions being drawn as to their appropriateness at different stages of therapy.

Analysis of graphs additionally revealed a general tendency for many therapeutic themes to mostly appear at specific points in time throughout the processes. This led to their

being viewed and termed as phases. It was discovered that many of these phases could be roughly categorized into specific stages of therapy and that their particular order held much therapeutic significance. The results of these findings are discussed below in the section titled "vocal phases".

A correlation between the graphs of vocal elements and vocal phases eventually began to emerge, as fundamental phases of the case studies were often found to correspond with specific uses of vocality. This served to draw conclusions regarding the suitability of implementing specific forms of vocality during each vocal phase. Furthermore, it served to shed light on the therapeutic objective inherent in the application of each vocal element. These findings are summarized in Table 2.

Vocal Elements

Various vocal elements were actively incorporated in the interventions employed throughout the voice therapy process. These forms of vocality were found to be crucial in furthering the therapeutic process.

I will now define and elaborate on the eleven vocal elements found to be incorporated in the vocal interventions of the cases studied. The definition given to each vocal element relates to its specific implications in this study. Though many of these elements have been previously discussed in existing voicework literature, they are generally incorporated in a novel fashion or to a distinctive end throughout this work. This is in accordance to best serving the abilities and therapeutic needs of the particular population studied. I will refer to the relevant sources throughout the text. Elements which are unique to the present inquiry will be explained without additional referencing. All elements are divided into categories based on the degree of verbality inherent in them.

Non-verbal elements.

Wind instrument work. The incorporation of wind instruments to induce vocality. Among others, these may include the harmonica, various whistles, recorder, melodica, ram's horn (shofar), kazoo and trumpets. Initially, the microphone is often used as a wind instrument as well. Similar to vocal production, wind instruments require manipulation of breath, lungs, lips, tongue and additional oral structures, promote awareness to inhalation and exhalation and result in (usually loud) sounds being produced through the mouth. The kazoo furthermore directly involves employing the vocal cords to produce sound, therefore requiring a client essentially speak or sing into it to produce its traditional sound. In cases of selective mutism (case study 3), this specific instrument was found to almost immediately preempt direct vocal use in therapy. Wind instruments employed in dialoguing improvisations with the therapist often served to stimulate ensuing vocal dialogues (case study 3).

Breath exploration. The exploration of different uses of breath. Many voicework pioneers recognize the importance of breathwork and incorporate it in their therapies (Austin, 2008; Sokolov, 2009, 1987; Thane, 2011). According to Sokolov (1987), "Taking in breath is drawing closer from the collective whole and outside, and channeling it into the inner self. To breathe in is to inspire, bring in, open and receive" (p.357). The inhibition of respiration has been associated with the inhibition of emotion (Reich, 1994). Therefore, breathwork was usually directed towards the deepening of the client's breathing and the freeing of breathing constrictions, thereby promoting relaxation, grounding clients in their bodies and releasing physical and vocal tension (as in case study 3). This work consequently allows the voice to flow more freely. Since such breathwork normally requires conscious effort entailing motivation, this was accomplished with children in an indirect, roundabout manner through exploration of breathing sounds and through play that naturally induced deep breathing. This

involved the blowing out of candles at varying distances, the blowing of balloons and of soap bubbles and more.

Toning. A continued held sound sung for the length of an exhalation which the singer experiences as a resonance in different parts of the body (Gardner-Gordon, 1993; Keyes, 1973). Such sustaining of vocal tones requires clients inhale profoundly, thereby promoting deep breathing which induces relaxation. This vocal element may be experienced as a natural extension to breath exploration and may serve as an introduction to actual vocal production in therapy. Toning has been incorporated by therapists for the purposes of meditation (Nakkach, 2012), healing (Goldman, 1992) and chakra activation (Gardner, 1997). Austin (2008) views mutual toning as a very intimate experience with the potential of grounding the client in their body and inducing an altered state of consciousness, and describes toning as "…the conscious use of sustained vowel sounds for the purpose of restoring the body's balance. Sound vibrations free blocked energy and resonate with specific areas of the body to relieve emotional and physical stress and tension" (p. 29). Interventions involving sustaining drawn-out notes were integrated into this work through vocal play or through the calming vocal improvisations depicted in case study 1.

Primary sounds. Initial, instinctual sounds primarily used by humans for the purpose of self-expression. This is closely related to what is described by Diane Austin (2008) as 'natural sounds': "…sounds the body emits spontaneously, sounds that are instinctive expressions of what we are experiencing at any given moment…" (p. 27). According to Austin (2003), "Claiming and giving voice to these stifled, repressed sounds is reclaiming aspects of ourselves that have been silenced or inhibited in our families and/or society in general" (p. 211). This work includes both spontaneously expressed and prompted primary sounds, such as yelling, crying, laughing, sighing, moaning, groaning, squealing, gasping and more. These pre-verbal forms of vocal expression have been used to help cope with and transform emotion for

centuries (Austin, 2009; Uhlig, 2006) as well as aid in the release of suppressed instincts stored in the body (Janov, 1970). Frequently introduced through improvisational vocal play, this element was employed for the purposes of prompting vocality, furthering non-verbal emotional expression and in aiding the client in relying on natural vocal instincts to initially release vocal inhibition. Specifically, the natural sound of yelling or shouting was often applied in work related to vocal empowerment and vocal confrontation (see case study 3).

Animal sounds. The vocal imitation of animals (jungle, barnyard, pets, etc.) through growling, roaring, howling, grunting, screeching and more. Newham (1999) has described promoting animal sounds through what he terms 'Primary Archetypal Regression' which promotes an "archetypal regression to a human primitivity and instinctuality" (p. 165) through animal positions, imagery and an animalistic form of vocalization. Animal imitation is not foreign to children. Thus, in this work these primitive sounds lent themselves to the promotion of vocal liberation and empowerment, gave voice to the client's varying vocal and emotional sides, were used to legitimize vocal expression of fears and intense emotions and to further explore client's vocal palette. This was achieved through animal dialogues, incorporating animal sounds in plays or stories, vocalizing while wearing animal masks or otherwise pretending to be animals, banishing fears by incorporating the vocal strength of an animal perceived as brave or strong, etc. Examples of such work have been described in case study 3.

Gibberish. The use of unintelligible or meaningless words or sounds. This vocal element encourages playful vocal communication and exploration of the musical or prosodic emotional elements of speech, such as timbre, tone, rhythm and silences. Winnicott (1971) has emphasized the importance of supported play and creativity in the formation of the ‘true self’. The use of gibberish has been noted in Roy Hart's improvisational dramatic theatrical work (Newham, 1998) and is reminiscent of the babbling used by the young infant during the first year of life to express himself and interact with caretakers. The caretakers' attunement to these

initial vocalizations are integral to the infant's development of an authentic sense of self and ability to connect with others (Stern, 1989). Gibberish was included in this work to prompt or permit client regression, promote vocal release and liberation and to encourage mother-child quality vocal interaction between therapist and client. Uses included nonsense songs, vocal "scribbles" and various therapist-client gibberish interactions. The latter has been depicted in case study 2.

Vocalization. Vocal improvisation that does not include actual words, but rather vowels or a combination of syllables and vowels devoid of specific verbal meaning. Vocalizing facilitates relaxing vibrations throughout the body which carry the potential to decrease anxiety and to develop entrainment (Clayton et al., 2005). Vocalizations were used in this work to promote such self-soothing abilities as well as to advance uninhibited vocal expression, give voice to fearful sounds, or as a precursor to vocal improvisation. Examples include free microphone vocalizations, structuring rhythmic vocalizations, vocalizing on the musical aspects of emotion (sans the burden of words), associative vocalizations and voicing sounds perceived as frightening. A vocalization example that involved self-lullabying on an open vowel may be found in case study 1.

Ingredient variation. Voicework promoting variation on vocal ingredients. Paul Newham (1999) lists ten basic ingredients he believes all human voices possess, with each vocal ingredient carrying certain psychological implications. Five of these vocal ingredients in particular were found to be of relevance to this model of voicework with children: Loudness, pitch (also referred to as 'note'), free air (generally referred to as the 'breathiness' of a voice), attack (which gives a voice its stress) and pitch fluctuation (which may occur in anxious individuals). Since vocal qualities arouse personal associations within the person, vocal ingredients may be perceived as both a symptom and a cause of emotional states (Austin, 2008; Newham, 1998). Work through vocal ingredients was therefore employed to develop vocal

flexibility, increase vocal loudness, empower the client, develop expressive aspects of the voice, and to explore and give voice to different aspects of the child's Self. These ingredients were accessed and modified through use of animal sounds, songs, vocalizations on varied emotions and on specific ingredients and through varied vocal games. Movement was combined with this work at times to further induce the vocal production of these ingredients. An example of ingredient variation work through the use of character voices may be found in case study 2, using a sweet "princess" voice vs. that of a destructive "monster".

Verbal elements.

Singing. The singing of readily available songs, either pre-composed or self-composed. Singing may release tension, loosen blockages of cellular energy, and access emotion and memories that may be locked in various location in the body (Joyce Moon, 1999). Singing has been incorporated as a vocal element to some degree in all existing voicework models. As a direct extension of speaking, singing shares with speaking many neural mechanisms such as its auditory-motor pathway as well as musical elements including rhythm, dynamics, diction, pitch and tempo (Patel, 2008). However, singing seems to have the additional advantage of stimulating the emotional limbic system and activating the emotive right hemisphere through control of pitch and melodic patterns (Thaut, 2005). Therefore, singing holds the potential to facilitate primary emotional expression as well as perhaps aid in the development of expressive language (Uhlig, 2006). Furthermore, singing's ability to increase phonation duration leads to prolonged breath exhalation, thereby potentially lowering anxiety levels (Patel, 2008). Singing further allows clients to bypass intellectual defenses often present in speaking therapy while the containing structure and predictability of the song allows the client to feel safer while expressing herself. This song structure may also allow the client to experience pleasure and satisfaction while expressing difficult emotions. According to Austin (2003), "Singing can enable clients to reconnect with their essential nature by providing them with access to, and an

outlet for, intense feelings. Singing offers a way for the disembodied spirit to incarnate because the way home can be pleasurable and the painful feelings can be put into an aesthetically pleasing form. Singing can provide clients with an opportunity to express the inexpressible, to give voice to the whole range of their personality" (p.211). Singing was used in a variety of ways and incorporated in nearly every phase of this voicework model for varying purposes. These include the prompting of verbalization (such as in case study 3), promotion of self-expression, personal empowerment, vocal expression of specific emotions, therapist-client vocal interaction, consolidation of vocal image and more.

Vocal improvisation. Improvisation incorporating the voice which include words alongside musical elements, composed and delivered in a spontaneous manner. Vocal improvisation has been incorporated as a key vocal element in previous voicework models (Austin, 2004; Newham, 1998; Sokolov, 1987). Among other goals, this element has been used in this current study to promote uninhibited verbal expression in therapy and to induce the articulation of emotional content significant to the client as well as to introduce a form of non-intimidating, emotion-oriented verbal communication to the therapy. Among various possibilities, this may include improvised story-singing, song improvisation, improvised rap and improvised vocal dialogues on significant content (as in case study 1).

Verbalization. Voicework incorporating the use of meaningful words, often pre-determined, as a key component. These served various purposes such as client empowerment, fear confrontation, the promotion of expressive speech and vocal structuring. Shouting significant words, chanting, sing-song speech, rhythmic speech and use of territorial vocal games (as in case study 3) were all incorporated to these ends. This specific element as described in this study has not been found to be typically depicted in existing voicework models, with the exception of the component of chant. Chant, which usually consists of

recurring and limited musical elements, has been described in the literature as repetitive singing of a phrase, which produces an altered state (Gass, 1999).

Further findings. Gibberish, natural and animal sounds all incorporate the playful use of the voice in therapy and may therefore be categorized as "vocal play". Play was often essential in gaining children's vocal cooperation and in releasing their voices in the therapy setting. The claim that "play" may also be integral in supporting the development of the child's emergent self is supported in the literature (Winnicott, 1971). While certain elements in this category were at times absent from a case study, some aspect of vocal play could be found in all cases studied, clarifying its unique contribution to the voicework process.

In all cases studied, toning always correlated with breath exploration, often appearing simultaneously. This strengthens a claim for employing both elements somewhat in tandem.

Wind instrument use was typically the first vocal element employed by the client with its frequency declining as the therapy process progressed, perhaps signifying its central role in prompting the client's initial vocal expression.

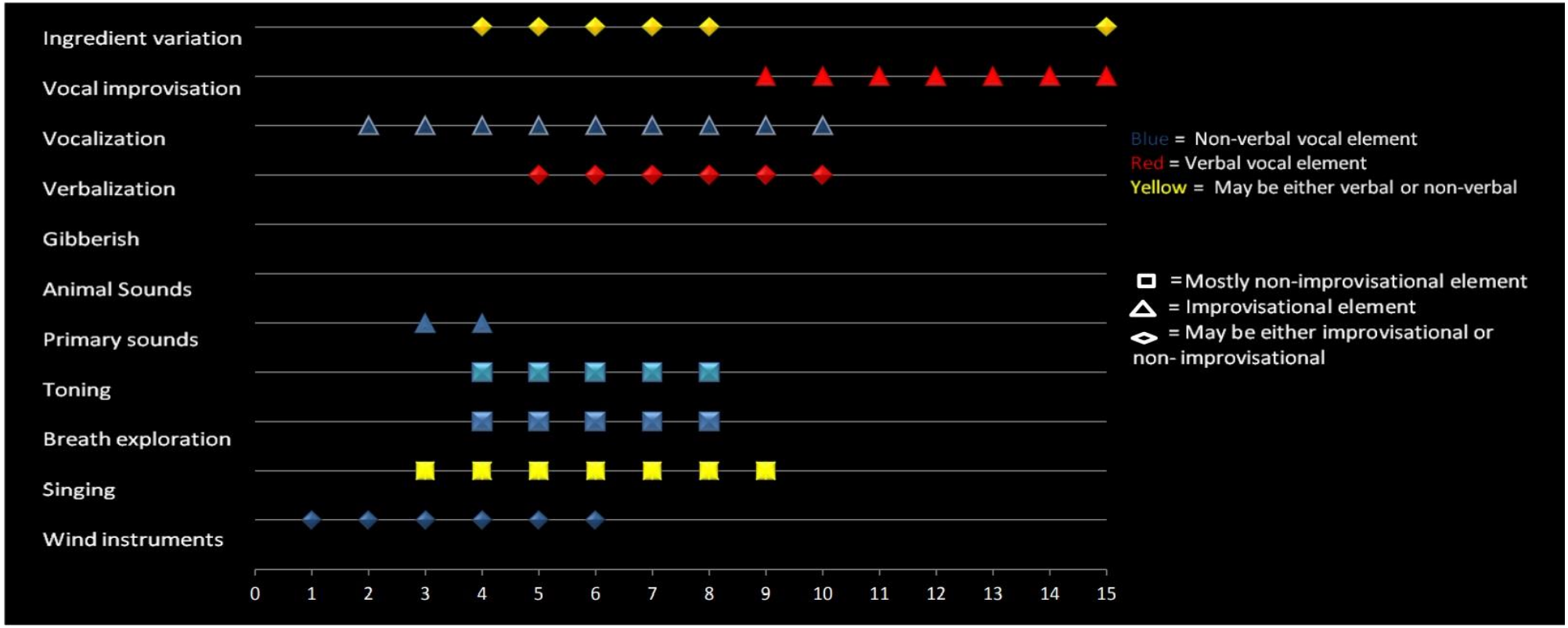
Non-verbal elements (wind instrument use, breath exploration, toning, vocalization, gibberish, natural, animal sounds and ingredient variation) were consistently found to dominate the earlier stages of therapy, seemingly preparing the client for the more verbal voicework (verbalization, vocal improvisation) which generally appeared afterwards and frequented the more advanced stages of therapy. Similarly, Non-improvisational vocal elements (singing, breath exploration) tended to precede, and perhaps pave the path for, more improvisational ones (vocalization, vocal improvisation, vocal play elements, ingredient variation) which tended to dominate the therapy as the process progressed. These findings emphasize the importance of timing in implementing specific vocal elements. They indicate that it may be conducive to the voice therapy process to first set a non-verbal and non-improvisational vocal foundation in therapy before incorporating more verbal and improvisational vocal elements.

Illustration of vocal elements in case studies. Figure 1 depicts graphs illustrating the assimilation of these vocal elements throughout the therapeutic processes described in the aforementioned case studies. The number of sessions in each case is indicated in Axis X, while vocal elements are labeled in Axis Y. Different shapes have been assigned to the vocal elements to represent their improvisational characteristic, defining them as either improvisational (triangle), mostly non-improvisational (rectangle) or possessing the possibility of being either improvisational or not (diamond). Colors have been further applied to define the level of verbality involved in each vocal element, with the blues indicating a non-verbal element, reds signifying a verbal vocal element and yellows used to denote that a vocal element may be employed in either a verbal manner or a non-verbal one.

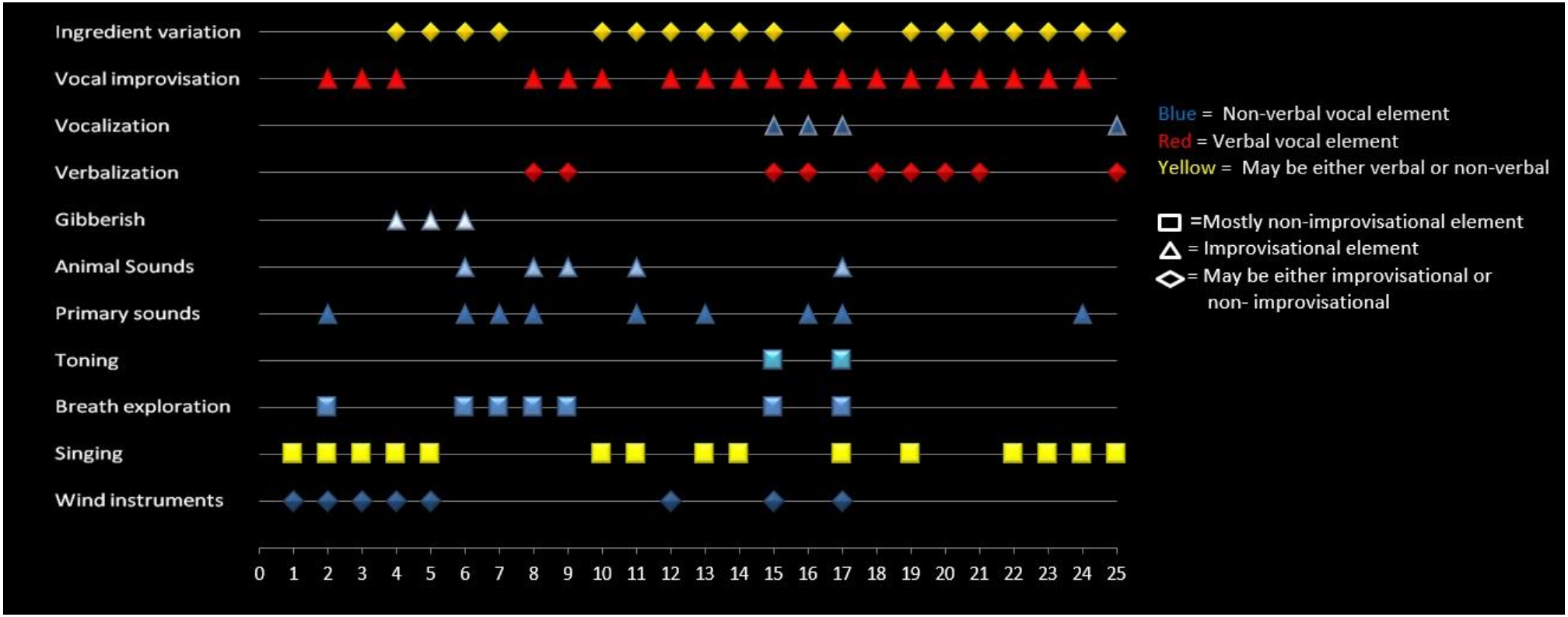
Figure 1

Vocal Element Graphs of Case Studies

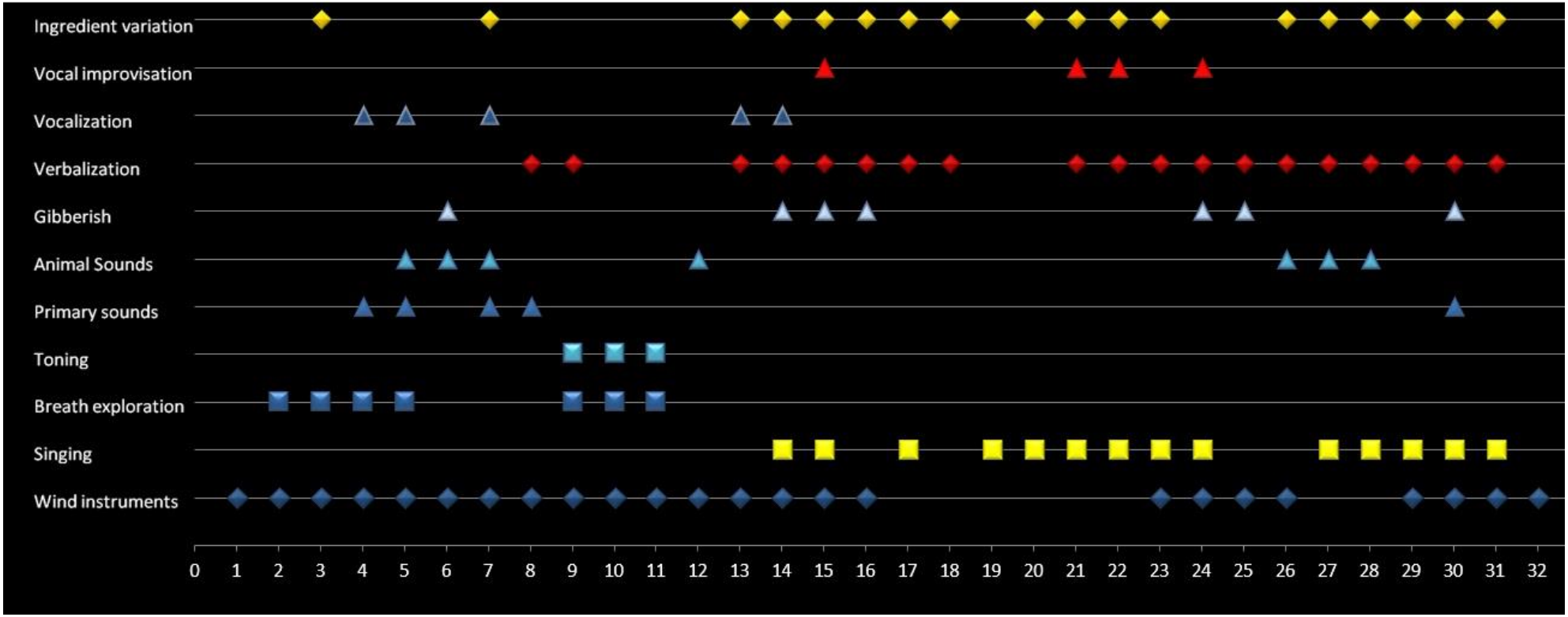
Case Study 1

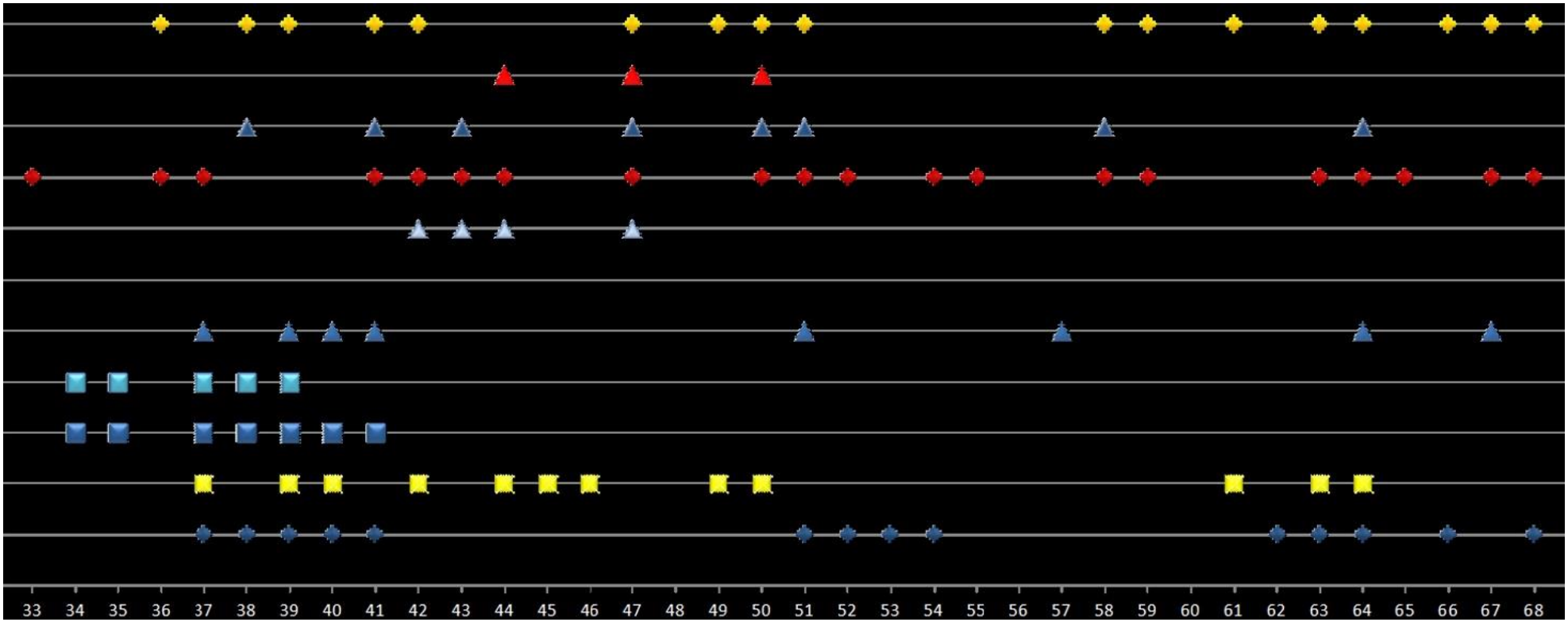


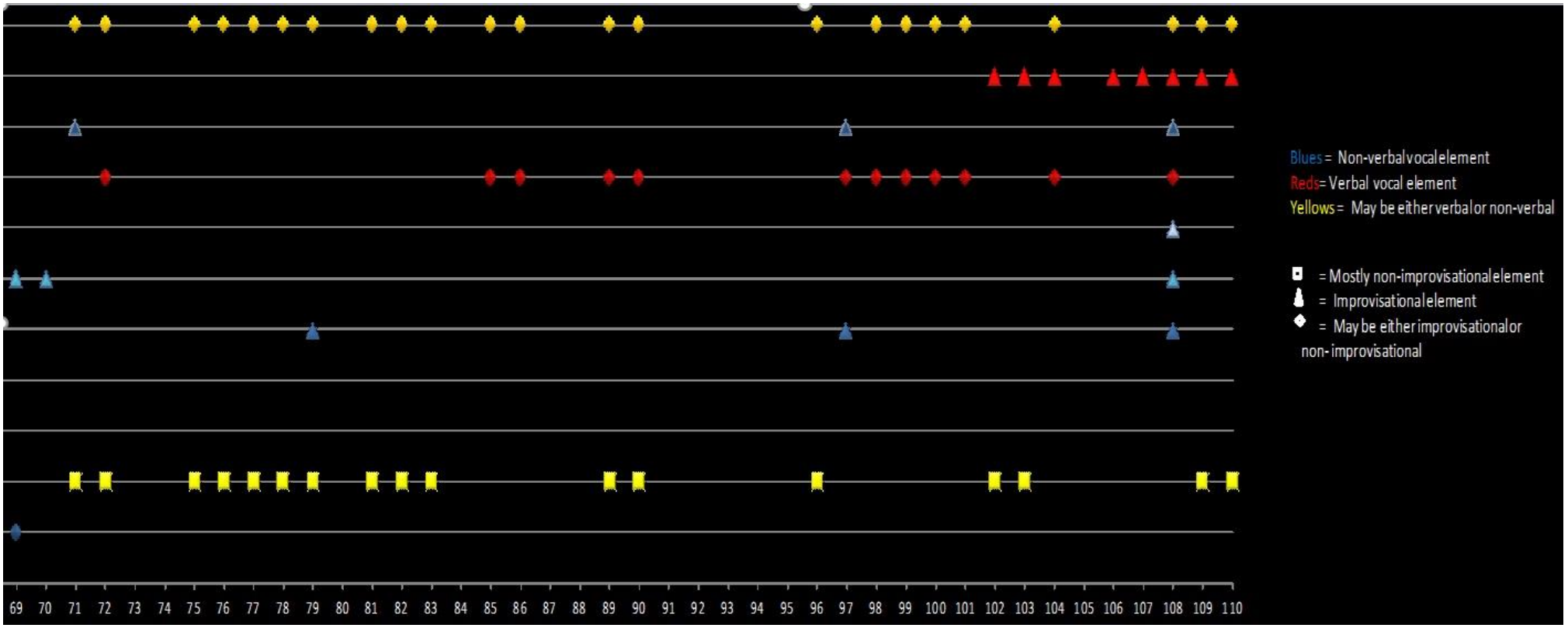
Case Study 2


Ingredient variation
Vocal improvisation
Vocalization
Verbalization
Gibberish
Animal Sounds
Primary sounds
Toning
Breath exploration
Singing
Wind instruments
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
Blue = Non-verbal vocal element
Red = Verbal vocal element
Yellow = May be either verbal or non-verbal
=Mostly non-improvisational element
= Improvisational element
= May be either improvisational or non- improvisational

Case Study 3


Ingredient variation
Vocal improvisation
Vocalization
Verbalization
Gibberish
Animal Sounds
Primary sounds
Toning
Breath exploration
Singing
Wind instruments
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32


33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68


Blues = Non-verbal vocal element
Reds = Verbal vocal element
Yellows = May be either verbal or non-verbal
= Mostly non-improvisational element
= Improvisational element
= May be either improvisational or non-improvisational
69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110

Vocal Phases

Nine central phases of therapeutic voicework with children were found to be relevant to this work. These phases were founded on the presented case studies and their analysis, including their accompanying graphs and summary of voicework techniques. These phases, which I term "vocal phases", roughly reflect the voicework process incorporated to reach the therapeutic goals set for the clients studied. The approach within these phases varied according to the dynamic of each case.

I will now attempt to define and elaborate on the nine vocal phases found to be fundamental to the voicework process.

Pre-vocal phase: Warming-up. The pre-vocal phase refers to the client's use of non-vocal mediums and to the therapist's use of her voice in therapy as precursors to voicework. This phase may serve as an initial warming-up phase in voice therapy and was found to necessarily preempt voicework and prepare clients for it in many cases. Instrumental work and interventions involving movement may prevail at this time, encouraging the freeing up of physical tension in anxious patients and consequently easing the muscular tension surrounding the vocal box.

The issue of breath was frequently addressed early on in this work, with breathwork incorporated to specifically ease vocal tension. Interventions including toning and singing served to facilitate deep breathing and to stabilize breathe. Instrumental use further encouraged the initial soundings of notes from sources other than from within the client. Instrumental interaction between therapist and client may contribute as well to lowering anxiety levels, setting the stage for the more intimate vocal interaction to transpire.

Wind instruments were found to be of particular assistance in preparing for and in prompting the use of voice in therapy throughout the cases studied. This was found to be of increased importance in cases where the client was unwilling or unable to initially use her voice

in the therapy setting. Work with such a client is described in case study 3. In that instance, wind instruments were incorporated to prompt the client's ability to create communicative sounds through use of her mouth and breath. The kazoo was subsequently introduced to induce vocal cord involvement. It additionally served to simulate a verbal conversational quality during our instrumental dialoguing interaction. This preparation allowed the client an unintimidating opportunity to gradually build-up to sounding her actual voice in therapy.

In additional cases studied, the microphone was found to be of particular usefulness in initially prompting spontaneous vocal exploration as well as vocalizations and singing. It was additionally found to be helpful in encouraging a client to continue the therapist's vocal expression.

Vocal aspects were further introduced into sessions by the therapist incorporating her own voice throughout the cases studied. This was done by singing pre-composed songs to the client and by vocally improvising to the client's movements, drawing motions or instrument playing. These served to model and to legitimize the use of voice in therapy.

Vocal togetherness: Forming a vocal relationship. This phase constitutes of forming a vocal relationship with the client through vocal experiences that emphasize mutuality and togetherness. It was found to be integral to both the continued reinforcement and development of the client's voicework as well as to the general progression of the therapeutic process, as it fostered the building of the therapeutic alliance. This phase was therefore applied in the earlier stages of therapy. Moreover, it was observed that this "vocal togetherness" further prompted clients' vocal contributions and willingness to cooperate in vocal interventions. These ends were initially achieved through various forms of vocal interaction between the therapist and client, e.g., the mutual singing of songs, turn-taking in vocal improvisations and in improvised story-singing, vocal accompaniment to the client's vocal expression and vocal dialoguing. Such an example may be found in case study 1, where client-attuned mutual free vocalizations and

song singing were helpful in engaging the self-reliant client, leading her to include the therapist in more of her initiations and to eventually allow her access to her emotional world.

Though the majority of the voicework incorporated throughout the therapeutic processes involved vocal interaction between therapist and client, the goal of incorporating these interventions towards furthering the therapeutic relationship was typically relevant to the more initial phase of therapy termed here as "vocal togetherness". Vocal mutuality further allowed the therapist to model vocal options for the client as well as to vocally contain and support the clients' vocality as well as to legitimize their vocal expressions.

Vocal liberation: Exploring and freeing the voice. This phase includes releasing the voice of its expressive inhibitions and constrictions, both physical and emotional, while exploring its multifaceted possibilities. It is possible to progress to this phase once the body tension that inhibits vocalization has been eased and the client begins to feel safe and comfortable in the voice therapy situation. This direction promotes free and spontaneous vocality as well as the vocal diversity and increased expressiveness often impaired in clients suffering from social anxieties. This is accomplished by allowing the voice to break through rigidity to freely and fully explore its many colors and expressive potential. This phase also strives to advance the client's basic enjoyment of using their voice, a reality not always evident in bashful or vocally insecure clients. As one of the initial phases in this model of voicework, it serves to prepare clients for the more personal vocal expressions characteristic of subsequent phases.

Vocal exploration in this phase was of a mostly playful nature and usually non-verbal, such as that induced through natural sounds, gibberish, animal sounds and free vocalizations. This "vocal play" promoted a playful atmosphere that facilitated therapeutic regression and promoted spontaneity, creativity and increased vocal freedom. Movement and percussion instruments were at times integrated with this voicework to advance uninhibited vocal release.

The therapist's role consists of facilitating client's vocal liberation by offering unique vocal opportunities, vocally modeling sought vocality and by validating and legitimizing client's ensuing expressions.

A sample of this phase's possibilities may be seen in case study 3. In this case, interventions were aimed at reducing the physical rigidity of the client with selective mutism and unfreezing her voice. These were incorporated to aid her in vocal release in general and during moments of intense fear and anxiety in particular. Such interventions included playful interactions such as gibberish conversations set to drumming, lion roaring dialogues as well as singing nonsense songs.

Vocal structuring: Focusing the voice. This phase aims to provide structure, order and focus to the client's vocality. It was found to be somewhat interchangeable with that of vocal liberation in clients requiring such regulation in their vocality. The component of rhythm was found to be integral in organizing speech and vocal expression, thereby contributing to their improved cohesiveness and comprehensiveness. Since rhythm is structured and easily anticipated, it may aid in providing cues that can facilitate the coordination and timing of speech production. This predictability of the rhythmic element also proved valuable in calming and focusing restless, overwhelmed and anxious clients. This phase's grounding, soothing and organizing effect on the client's demeanor and speech proved useful in gaining their cooperation, motivating verbalizations and in furthering therapist-client interactions. Structuring was largely advanced through rhythmic vocal interventions set to a moderate speech-rate tempo and stable rhythm, often incorporating concrete speech. These included rhythmic gibberish and vocalizations, rhythmic speech, chanting and improvised rap. The therapist served as facilitator of these rhythmic interactions, eliciting, modeling and structuring them, while vocally grounding the client when possible. An example of such work may be found in case study 1 with a distracted and seemingly hyperactive client who had a tendency

to babble incessantly and to stutter. Rhythmic verbal and vocal interactions set to a steady, structured rhythm were incorporated in this case, leading to the client's increased ability to focus on mutual activities and to express herself calmly and coherently in the therapy setting.

Vocal emotional expression: Giving voice to the psyche. This phase focuses on aiding the client to develop the expressive potential of her voice and give voice to inhibited, pent-up and unexpressed emotions. In this manner, the client may positively experience emotions sensed to be threatening or frightening through the non-threatening and often pleasurable medium of song and vocality. The voice is naturally and intimately connected to the expression of emotions which makes it an ideal medium to meet this purpose. This phase was incorporated at different stages throughout the therapy process. The voice promoted during this phase is an authentic and emotional one that may give acoustic shape to emotion, rather than a proper or aesthetically pleasing voice. This voice may later be given structure in the form of song. Though voicework in this phase may be both verbal and non-verbal, the latter often precedes the former. Since emotions emanate from a preverbal level of the psyche which is often beyond words, non-verbal vocal expression holds the potential to release emotion from the burden of words. Additionally, it permits the client to return to an infantile mode of expression and directly express his distress through non-verbal vocal sounds, freeing him from the need to articulate and communicate them verbally. This may also promote a vocal cathartic process by allowing the client to discharge trapped emotions.

Beyond verbal expression alone as in speech, the singing voice brings an additional emotionalized dimension to this work, allowing clients to express emotion with increased intensity and authenticity. The singing voice further engages more of the brain's right hemisphere, possibly circumventing cognitive inhibition and leading to increased emotional and unrestrained vocal expression. The added aspect of improvisation to this vocality further advances the spontaneous and uninhibited expression of musical components as well as verbal

components in vocal expression. Therefore, the combination of both singing and vocal improvisation may prove a powerful tool in increasing freedom of vocal emotional expression. This phase may also serve as a step-stone towards improved traditional verbal emotional expression. An example of such work may be observed in case study 1 in which melancholic vocal improvisations on an emotionally reserved client's gloomy drawings were vocally supported by the therapist and eventually led to candid improvised singsong conversations between the client and therapist on emotionally challenging topics.

The therapist's role largely lies in guiding the client towards releasing emotion through voice, expanding the emotional range of the voice by infiltrating the voice with varied emotional tones (excitement, grief, fear, disappointment, etc.), and in helping the client feel comfortable and safe while giving voice to these emotions through vocal containment. Voicework beneficial to this phase may be elicited by singing songs that evoke or encourage emotional expression of varying emotions, improvised story-singing, improvised sing-song dialogues, vocalizing or vocally improvising on emotions or on situations evoking emotions, vocalizing or singing as characters (puppets, masks) that may elicit different emotions and modification of vocal ingredients to infuse voice with expressiveness by accessing vocal qualities appropriate for the expression of each emotion (e.g., sadness= lowered pitch, decreased volume; anger= increased volume, increased attack, decreased free air; fright= increased pitch fluctuation, raised pitch, increased free air).

Vocal empowerment: Embodying the power of the voice. This phase consists of empowering the clients' voice and subsequently or additionally emotionally empowering the client through their voice. An empowered voice instills self-confidence and self-assurance and adds increased assertion and conviction to the voice. Likewise, an emotionally empowered client will likely find this transformation reflected in their voice. The empowered voice is the antithesis to the frightened, defeated voice often sounded by anxious, fearful children. This

work supports, leads up to and makes possible that of vocal confrontation of fears, a phase that often appears as a parallel stage. Often a client will first play a wind instrument in an empowered manner before applying this quality to the voice. This phase combines both verbal and non-verbal vocal elements. These include empowering mantras, vocal volume games, territorial vocal games and vocalizations accompanied by exaggerated movements and percussion instruments. Playing back clients' ensuing vocal recordings was found to further benefit this process by reinforcing and reaffirming this newfound powerful voice.

Beyond facilitating empowering voicework, the therapist's role included the singing of empowering songs to or with the client and containing the client's ensuing empowered vocal expressions. An example of such work may be found in case study 3, in which playful vocal volume games, such as attempting to out-sing herself on previous audio recordings and vocalizing on a crescendo, were used to gradually unleash the whispering, bashful client's confident and assertive voice.

Vocal confrontation of fears: Singing the fears away. This phase includes both incorporating the acoustic qualities of the feared stimulus in the client's voice as well as confronting fears straightforwardly through voice. The former allowed the client to personally experience and gain a sense of control over the sounds or noises she feared most and possibly contributed to a gradual desensitization to these sounds. This aspect incorporated mostly non-verbal vocal elements, such as animal sounds, natural sounds, vocalization on fears and associative vocalizations. These may be prompted by the therapist providing exposure to relevant acoustic stimuli or by improvising songs which incorporate the client's fears, leaving space for their vocal interjections. The latter aspect of this phase involves facing and confronting all things feared from a place of vocal empowerment, vocally banishing the feared stimulus (represented by a puppet, instrument, picture, etc.) through both verbal and non-verbal vocal elements. These may include vocal battles, opposing vocal sounds, assertive dialoguing

with feared stimulus and shouting fearless mantras and may incorporate playfully simulated situations. For instance, in case study 2 the client would confront and chase away monster puppets during plays we put on in the darkened clinic through loudly drumming while yelling at them to leave her alone and chanting "I'm not afraid!". She would later incorporate the feared monster's imagined vocal quality into her own voice, singing and speaking as him.

This phase was found to be integral in assisting children in dealing with their fears in a direct fashion. Vocal support, reinforcement and containment as well as continued reassurance from the therapist were essential during this phase.

Vocal image: The newfound voice. This phase aims to promote vocal awareness and the process of aiding the client to explore and experience the many voices within her and discover the voice(s) truest to her. Through this work, the client may further discover vocal aspects that have been underused, misused, lost or yet to be found. This phase usually typifies the more advanced stages of voicework. As the voice is a primary channel through which we communicate to ourselves and to the world who we are, vocal quality affects and reaffirms the way a client perceives herself and may cultivate and solidify not only her vocal identity but personal identity as well. Clients may have become identified with a specific, limiting vocal image of themselves (e.g., the "quiet" child), which may be expressed through their vocal quality. This then reinforces and reaffirms their image of themselves as such. Since parts of the self may be concealed, projected or misrepresented through the voice, this work might be helpful in encountering parts of the self and working towards a greater sense of integration. Vocal quality exploration may aid the client in this process while allowing her to develop or modify her vocal identity. This may potentially alter the way the client perceives herself and consequently, the way others perceive and accordingly behave towards her.

This process may lead to uncovering and discovering new, unexpressed or undeveloped parts of the clients' Self or to the acceptance and merging of existing parts and voices. This

newfound voice may embody the client's true Self and reflect her progress in therapy. Sounding this voice provides opportunity for her to hear herself in a fresh and unfamiliar way. She may then sound this new voice for others to hear.

This is mainly achieved non-verbally through the modification of vocal ingredients reflecting personal characteristics and qualities, in accordance to therapeutic goals (e.g., "the brave voice"= increased volume, lowered pitch, decreased pitch fluctuation, increased attack). These vocal qualities may be explored through vocal play and through vocalizations on traits. Further reinforcement of vocal image may be realized through verbal vocal elements. These may include songwriting and singing of identity songs, identity consolidating mantras and singing or speaking as varied characters in improvised plays. Playing back clients' vocal recordings for them to listen to allowed them to hear themselves differently and were effective in further consolidating the developed identity and in reaffirming sense of self.

Case study 2 provides an example of such a phase, where voicework was aimed at integrating the client's scary, evil "monster" voice with her sweet and virtuous "princess" voice to bridge the split in her perception of herself and allow her to accept the multifaceted aspects of personality. The therapist's main role in this phase consists of facilitating the client's vocal experimentation and legitimizing the emerging vocal image.

Vocal processing: Internalizing and parting. This final and generally concluding phase includes internalizing the process experienced, revisiting significant moments and insights and summarizing the overall progress made, newfound vocal qualities, abilities and image. It involves consolidation, summarization and integration of all therapeutic aspects worked on and developed throughout the voice therapy process. This process incorporates mostly verbal elements such as summarizing songs composed and sung for or with client to affirm her progress and insights, though non-verbal elements as well, such as revisiting the many voices discovered or explored throughout the therapy process. Listening to vocal recordings made

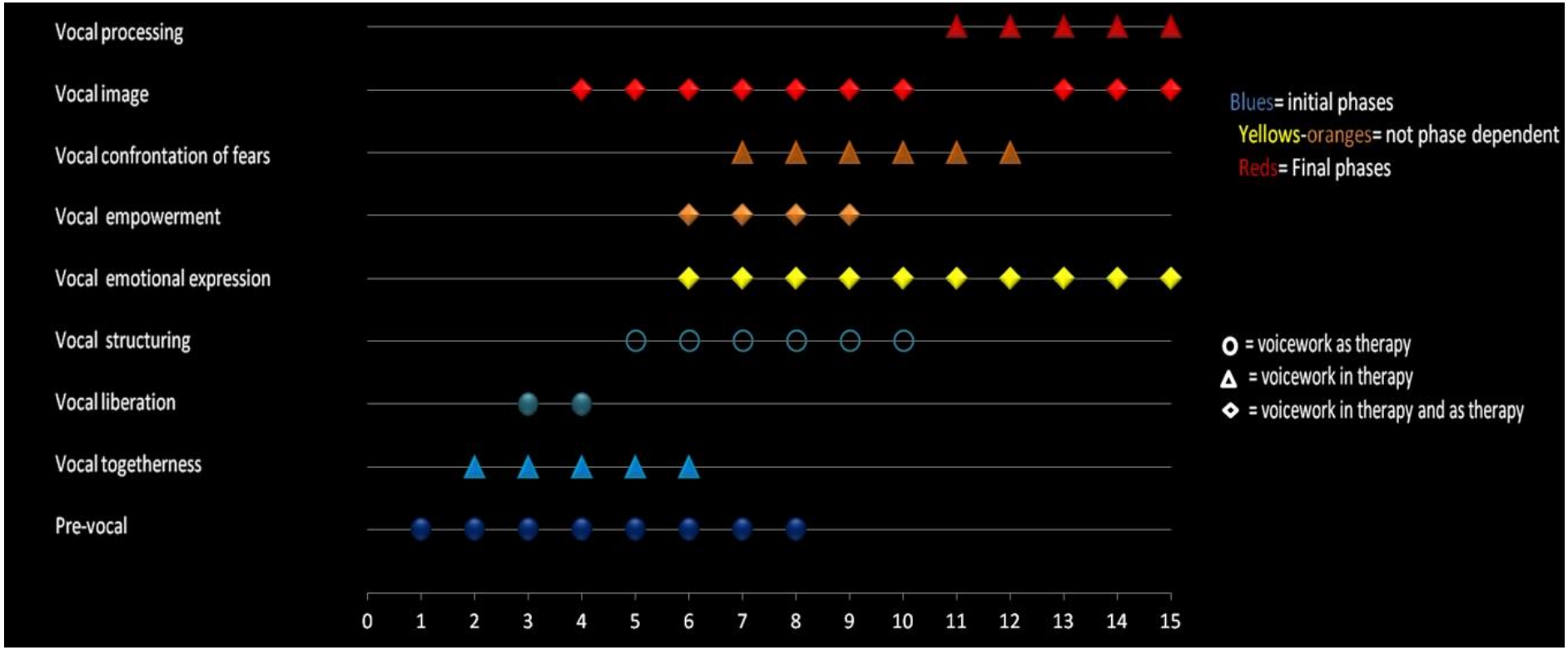
throughout the process and comparing ones from earlier stages to those of a later stage may prove especially effective during this phase. It is fundamental that the therapist summarize and reflect on the process in a way that may be understood and processed by the client on a meaningful cognitive level as well as on an experiential one. Since this phase typically characterizes the final stage of therapy, the farewell from the therapy and therapist may be integrated with this work and processed at this time as well. This may be achieved for instance by singing or improvising a farewell song with the vocal emotions that best express the client's feelings towards the situation, as demonstrated in case study 3. Here the client identified the emotions present in each paragraph of a farewell song she composed and performed the song accordingly, vocally infusing each paragraph with the appropriate emotion.

Illustration of vocal phases in case studies. The following graphs (Figure 2) illustrate these integral phases across the therapeutic process described in the aforementioned case studies. The number of sessions in each case is indicated in Axis X, while vocal phases are labeled in Axis Y. Different shapes have been included to represent the specific employment of the voice in each phase, whether primarily as the therapeutic agent of change in itself ("voicework as therapy"= circle), as a facilitator of therapeutic progress beyond that achieved through the voice itself ("voicework in therapy"= triangle) or potentially as both (= diamond). Colors have been further applied to define the relevance of the vocal phases to the stages of therapy, with the blues indicating phases generally appearing at the initial stages of therapy, reds signifying those phases mainly emerging at final therapy stages and yellows or oranges used to denote those phases not typically reserved to a specific stage.

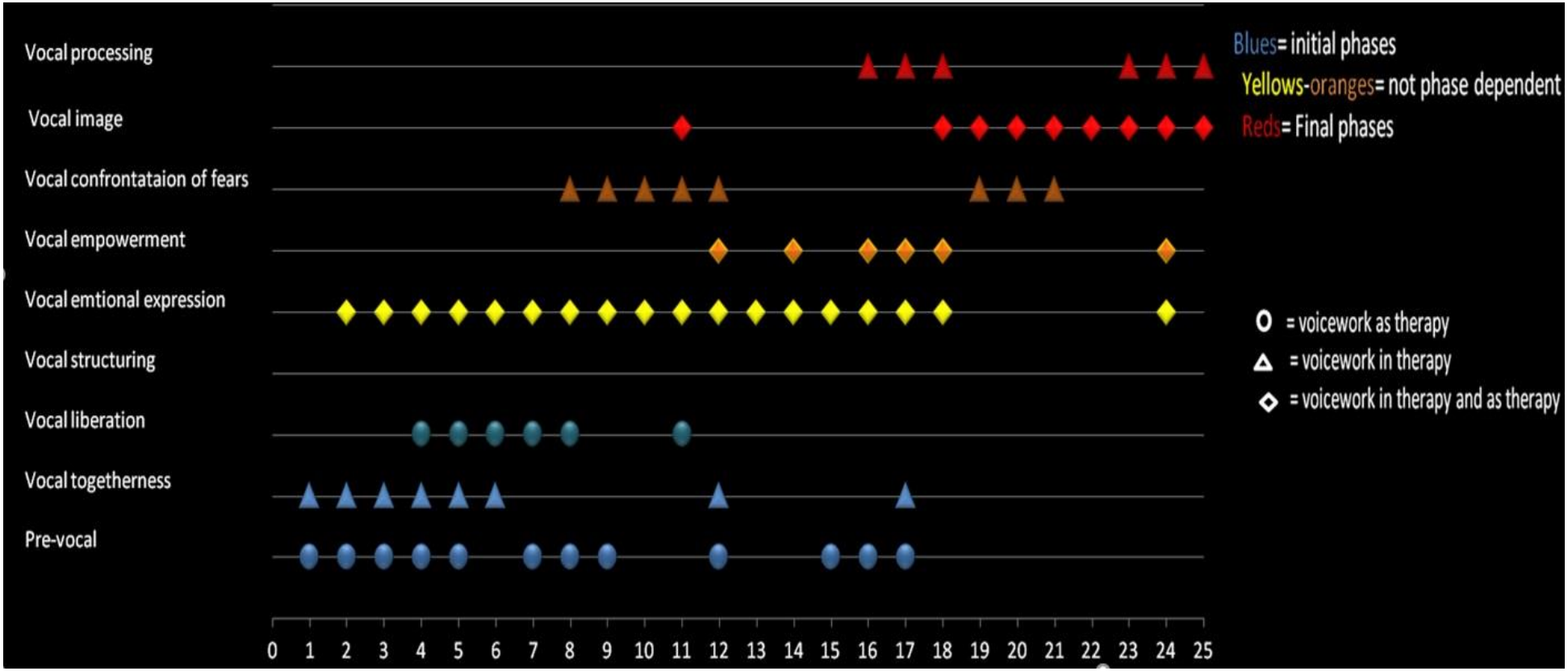
Figure 2

Vocal Phase Graphs of Case Studies

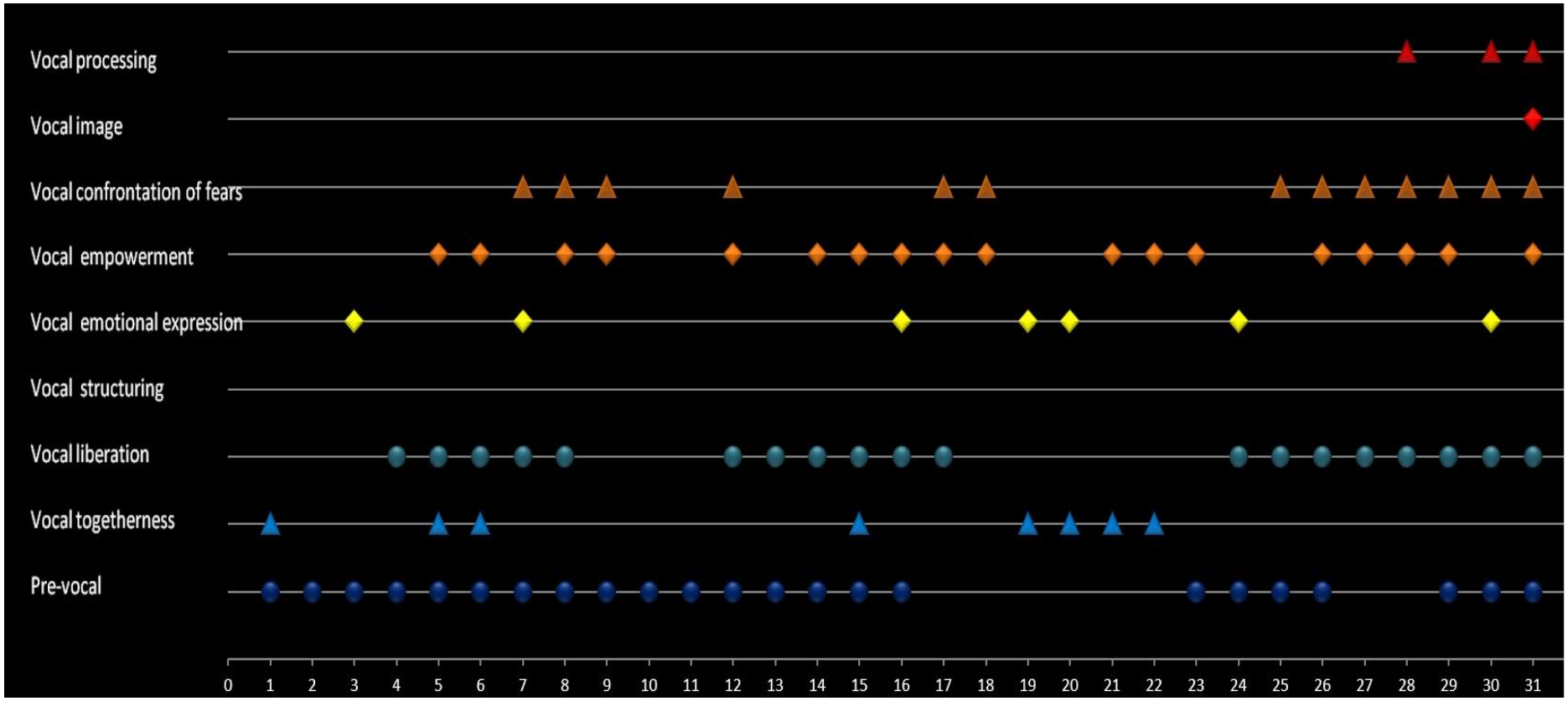
Case Study 1



Case Study 2


Vocal processing
Vocal image
Vocal confrontataion of fears
Vocal empowerment
Vocal emtional expression
Vocal structuring
Vocal liberation
Vocal togetherness
Pre-vocal
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
Blues= initial phases
Yellows-oranges= not phase dependent
Reds= Final phases
= voicework as therapy
= voicework in therapy
= voicework in therapy and as therapy

Case Study 3


Vocal processing
Vocal image
Vocal confrontation of fears
Vocal empowerment
Vocal emotional expression
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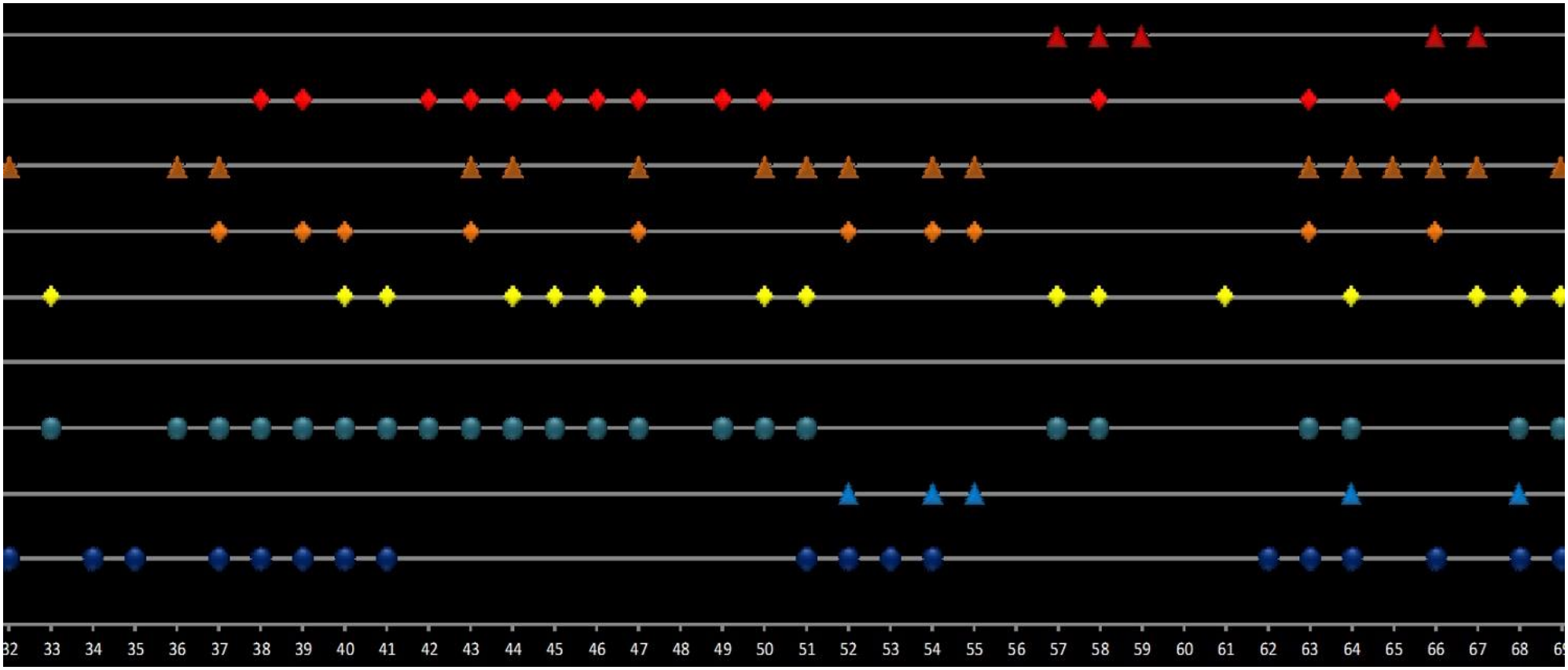
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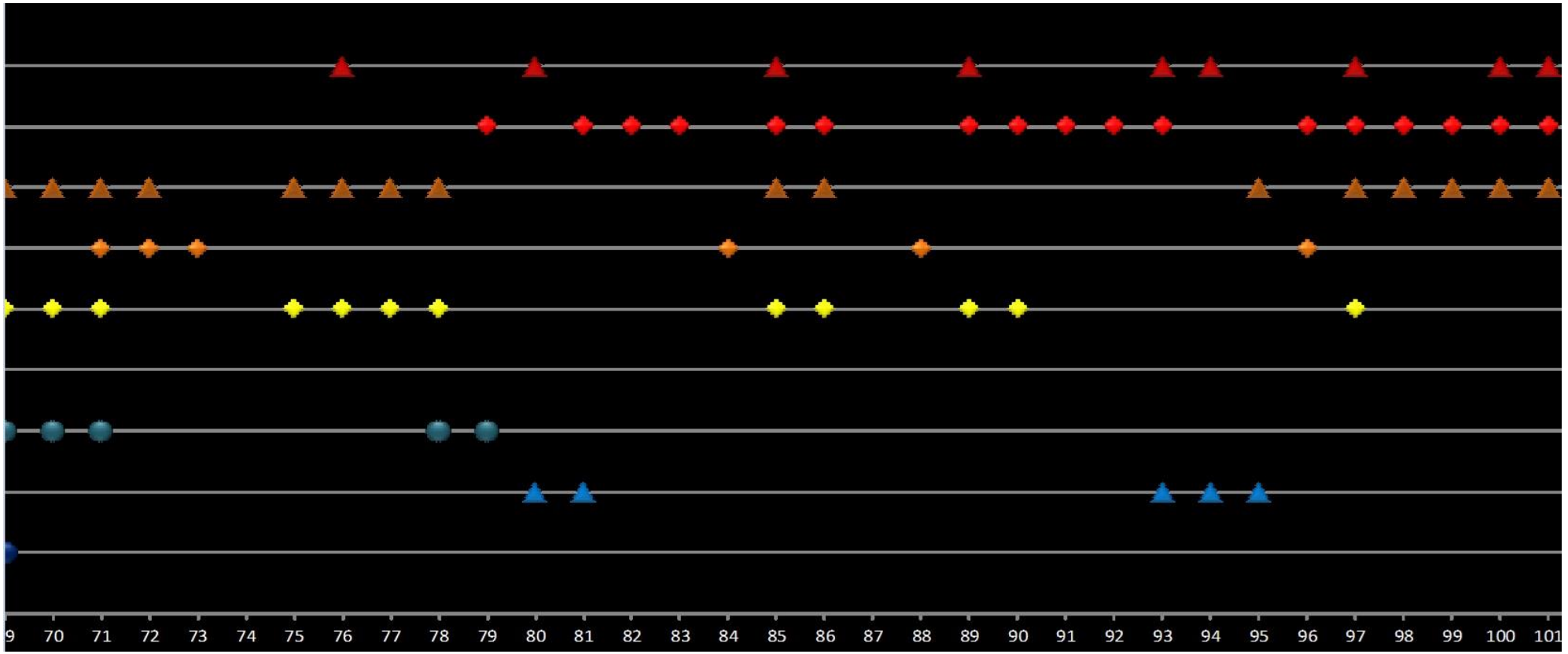
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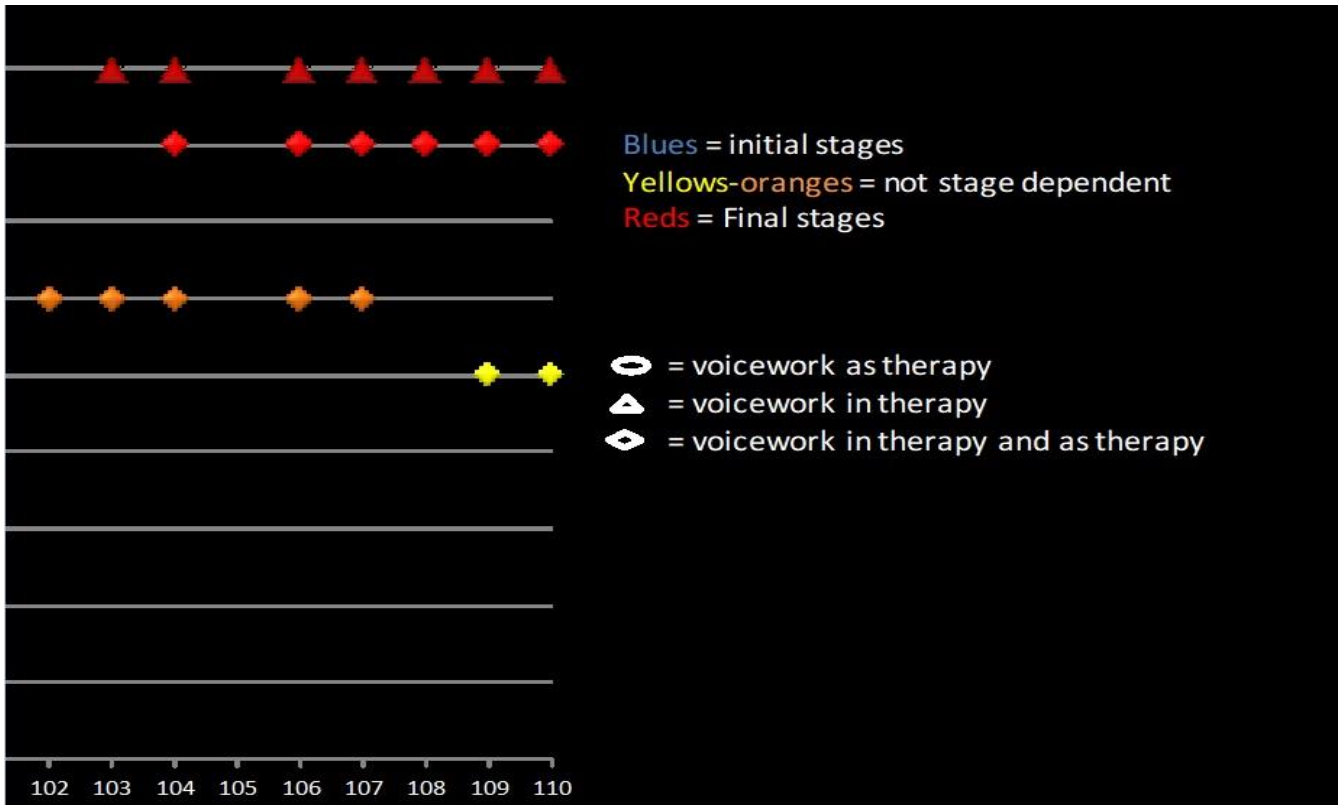

Blues = initial stages
Yellows-oranges = not stage dependent
Reds = Final stages
= voicework as therapy
= voicework in therapy
= voicework in therapy and as therapy
102 103 104 105 106 107 108 109 110

Conclusions. As visually summarized in Figure 2, the initial stage of voice therapy typically included the phases of: Pre-vocal work, vocal togetherness and vocal liberation. The phase of vocal liberation was replaced by vocal structuring in cases where the client's voice was already being used in a liberated manner but lacked the focus and structure imperative to her progress. Among the phases mentioned, pre-vocal work and vocal togetherness were generally the very first techniques to be employed in the therapy process. These two initial phases served to set the foundation for both the introduction of voicework into therapy and the formation of a therapeutic alliance integral to the therapy process. Characteristics of these phases persisted at times into further stages as necessary. The use of voicework as therapy was dominant during this initial stage in which focus was placed on laying the groundwork necessary for the therapeutic process: Calming the client's anxieties, forming a therapeutic relationship, prompting the client's vocality and promoting the uninhibited use of her voice. Vocal liberation in particular tended to lead to increased vocal expression.

Phases that typically followed the initial stage and were more generally found to frequent the intermediate stage of therapy included: Vocal emotional expression, vocal empowerment and vocal confrontation of fears. Among these, vocal emotional expression was the first to be employed. Vocal empowerment and vocal confrontation of fears were frequently employed nearly concurrently as they tended to support one another. A positive correlation could be detected among them as these techniques tended to reinforce the presence of one another. Among this category, voicework was employed both as therapy as well as in therapy.

Phases customarily employed in the final stage of voice therapy included those pertaining to vocal image and to vocal processing. These phases both represent the culmination of the voice therapy process as both involve some level of summarization: Vocal image allows the client to experience himself differently through his newfound voice, while through vocal processing the client may recapitulate and assimilate therapeutic themes central to the therapy

process. Thus, voicework was employed both as therapy as well as in therapy throughout this stage.

Voicework phases were applied as needed based on the specific case presented, as the therapeutic approach varied with each individual. Not all phases were incorporated in every case study as there is no set formula for this work and each client has her personal route to wellness. Those appearing in every case examined included: Pre-vocal, vocal togetherness, vocal emotional expression and vocal image. All cases studied employed voicework both as therapy as well as in therapy. Overall, vocal emotional expression was found to be the phase most frequently applied in voicework with the population studied. Furthermore, it was observed that the longer the therapy process, the greater the dispersion of the varying phases beyond the scope of their original stages.

Vocal Elements and Vocal Phases: A Cross-Tabulation

All voicework cases were found to possess similar fundamental phases throughout the process, often corresponding with specific uses of vocality. A cross-tabulation was therefore drawn among these aspects of vocal elements and vocal phases, found to be integral to voicework with children suffering from fears and anxieties. This relationship is summarized in the accompanying results table (Table 2), which roughly indicates the frequency of each vocal element's application throughout the various vocal phases. Frequency options include a vocal element being typically, occasionally or not typically applied during a vocal phase. These possibilities are signified by rectangles of varying color, with a blue rectangle indicating that a vocal element is frequently applied, a yellow one denoting it may be occasionally applied and a white one implying the particular vocal element is not typically applied during the vocal phase.

Table 2

Cross-Tabulation among Vocal Elements and Vocal Phases

	Wind instrument work	Singing	Breath exploration	Toning	Primary sounds	Animal sounds	Gibberish	Verbalization	Vocalization	Vocal improvisation	Ingredient variation
Pre-vocal											
Vocal togetherness											
Vocal liberation											
Vocal structuring											

Vocal emotional Expression		■			■	■		■	■	■	■	
Vocal empowerment	■	■			■	■		■			■	
Vocal confrontation of fears		■			■	■		■	■		■	
Vocal image		■						■	■	■	■	
Vocal processing		■						■	■	■		

■ = Typically applied

■ = Occasionally applied

□ = Not typically applied

It may be concluded from this table, that the vocal elements most typically applied during specific vocal phases are as follows:

- Pre-vocal: Wind instrument work, breath exploration, toning
- Vocal togetherness: Singing
- Vocal liberation: Primary sounds, animal sounds, gibberish, vocalization
- Vocal structuring: Verbalization
- Vocal emotional expression: Singing, primary sounds, vocalization, vocal improvisation, ingredient variation
- Vocal empowerment: Singing, primary sounds, verbalization, ingredient variation
- Vocal confrontation of fears: Primary sounds, animal sounds, verbalization, ingredient variation
- Vocal image: Singing, vocal improvisation, ingredient variation
- Vocal processing: Singing, vocal improvisation

The vocal element of singing was found to be most dominant in its frequency of application among the vocal phases, as its versatility lent itself to the therapeutic aims of various phases. The vocal elements of wind instrument work, breath exploration and toning were found to be the least typically applied vocal elements throughout the phases, as their usefulness was mostly restricted to the initial phase of voicework. These findings further consolidate this voicework model and may improve the efficacy of its practical implementation.

Discussion

Voicework Model Principles

Vocal phases. Nine phases have been identified as central to the voicework model investigated. These are: Pre-vocal work, vocal togetherness, vocal liberation, vocal structuring, vocal emotional expression, vocal empowerment, vocal confrontation of fears, vocal image and vocal processing. Though they tend to overlap, these phases commonly emerge in the order presented in this work throughout each therapy process, with the few exceptions noted. Each phase logically sets the stage for the next to occur, thus permitting a vocal therapeutic process to transpire. These vocal phases have been found to characteristically emerge during different stages inherent in the voicework process with the population studied, correlating with the distinct objectives which generally typify these stages. The initial stage in therapy generally included the phases of pre-vocal work and vocal togetherness alongside that of either vocal liberation or vocal structuring (which were applied interchangeably according to case). The intermediate stage of therapy comprised of vocal emotional expression, vocal empowerment and vocal confrontation of fears. Finally, the concluding stage of voice therapy consisted of vocal image and vocal processing.

The role of vocal use within each phase has additionally been examined, pointing to a general trend of the phases tending to dominate initial stages of therapy generally including more use of the voice "as therapy". This implies that during that stage the use of voice in itself was the key therapeutic factor. This vocal application has been hypothesized to meet the clients' initial needs in therapy as well as to prompt vocality. In this manner it lays the foundation for the voicework process as well as the increased application of the voice "in therapy". The term "in therapy" in this paper implies that the voice is employed towards promoting an emotional objective not necessarily related to the voice itself.

Vocal elements. The use of combinations of specific vocal elements has been found to characterize the client's vocal involvement in each phase (Table 1). The vocal elements identified in this work have been condensed into eleven classifications, each containing the potential of diverse voicework application. These vocal elements are: Wind instrument work, singing, breath exploration, toning, primary sounds, animal sounds, gibberish, verbalization, vocalization, vocal improvisation and ingredient variation.

These vocal elements have been divided into non-verbal and verbal categories based on the degree of verbality required of the client applying the vocal model. The component of improvisation typically inherent in the application of each vocal element was addressed as well (Figure 2). The emerging pattern from the vocal element analysis has revealed that non-verbal and non-improvisational elements are generally more commonly applied during the initial stages of the voicework process, setting a vocal foundation that appears to pave the way for integrating vocal elements which require more verbality and improvisation in more advanced stages of therapy.

The varying aspects of this model are summarized in the table below (Table 3):

Table 3

Vocal Model Outline

Vocal phase	**Typical stage**	**Therapeutic aims**	**Main role of voicework**	**Main vocal elements used by client**	**Degree of client verbality**	**Degree of client vocal improvisation**	**Therapist's vocal role**
Pre-vocal	Initial	Preparing client for voicework, Reducing physical and emotional tension, Prompting vocality	As therapy	Wind instrument work, breath exploration, toning	Low	Low	Modeling, legitimizing
Vocal togetherness	Initial	Building therapeutic relationship with client	In therapy	Singing	Medium	Low	Dialoguing, containing, supporting
Vocal liberation	Initial	Releasing voice of physical and emotional inhibitions	As therapy	Primary sounds, animal sounds, gibberish, vocalization	Low	High	Modeling, legitimizing, reinforcing
Vocal structuring (*may be interchangeable with vocal liberation)	Initial	Organizing and focusing client's vocality	As therapy	Verbalization	High	Medium	Structuring, grounding

Vocal emotional expression	Intermediate	Developing vocal expressiveness, Expressing emotions	As and in therapy	Singing, primary sounds, vocalization, vocal improvisation, ingredient variation	Medium	Medium	Reflecting, containing, supporting, legitimizing
Vocal empowerment	Intermediate	Physically empowering the client's voice, Emotionally empowering the client through her voice	As and in therapy	Singing, primary sounds, verbalization, ingredient variation	Medium	Medium	Modifying, containing, reinforcing, affirming
Vocal confrontation of fears (* May occur simultaneously with vocal empowerment)	Intermediate	Facing and overcoming fears	In therapy	Primary sounds, animal sounds, verbalization, ingredient variation	Medium	Medium	Supporting, reinforcing, containing
Vocal image	Advanced	Exploring the varied voices within the client, Developing and integrating vocal identity	As and in therapy	Singing, vocal improvisation, ingredient variation	High	High	Modifying, affirming, reinforcing
Vocal processing	Concluding	Internalizing and summarizing process, Departure from therapy and therapist	In therapy	Singing, vocal improvisation	High	High	Relaying information, reinforcing, affirming, reflecting

Clientele

The model suggested may be used to treat a variety of clients and ailments as may be concluded from the examples sampled. These may be clients who initially present with vocal symptoms: Unusual vocal characteristics, disorders of the voice, lack of vocality or others. These vocal symptoms may indicate an underlying emotional issue which may be worked on as well through voicework. This voicework approach may additionally be ideal for clients for whom voicework is the preferred therapeutic medium through which they may express themselves and undergo a therapeutic process due to their personal inclinations or specific needs, which may be met through voicework. A client may likely be concomitantly benefitted by this model for both possibilities thus far mentioned.

Therapist's Role

In addition to the therapeutic functions commonly fulfilled by the music therapist, the role of the therapist in the model proposed includes a variety of functions relating to the voice. The therapist's role requires vocal endurance as the vocal component of any given therapy session may be extensive. The therapist must be able to use her voice in a flexible, playful and uninhibited manner while listening closely to the client's vocal expression and adapting herself to the client's emotional needs. All the above mentioned requirements are necessary for the therapist incorporating this model to fulfill her multifaceted role in the voicework session.

Vocal elements are often initially introduced into sessions by the therapist incorporating her own voice in the therapy sessions, thereby modeling vocal elements and applications to the client. The therapist incorporating her own voice not only aids in eliciting the client's vocality, but additionally serves to legitimize the very use of voice in therapy as well as the varied applications introduced throughout the process. The therapist is in fact required to be able to employ every vocal element presumed of the client (verbal, non-verbal, improvisational, non-improvisational, etc.) and more. Throughout the voice therapy process, her role may entail

creating opportunities for vocal expression, applying vocal interventions suited to each phase's objective, guiding and facilitating the client's vocal experimentation, liberation and expression as well as validating and legitimizing the client's ensuing vocality. Her specific vocal role may be applied in unison with the client's voice, in response to it or independently from it. It may include promoting vocal modification, vocally modeling, grounding, dialoguing, containing, reflecting, reinforcing, supporting, structuring, and relaying information. Among other things, this may require vocally improvising and singing to and with the client and entering into varied forms of vocal interactions with him. The therapist's primary vocal role in each phase is summarized above in Table 3.

Voicework Model Theoretical Foundation

The significance of many of the concepts found integral to the phases of the voicework model studied may be established through the professional literature. The preliminary pre-vocal phase which serves as the model's basis was frequently found to be essential, as the voice tends to be experienced as particularly intimate and revealing. This is often the case, as the voice is a personal instrument that resonates from within. Cooke (1952) maintained that: "The human voice is the only musical instrument with a heart, mind and a soul" (p. 15). The fact that the therapeutic voicework proposed in this study is often implemented with clients whose difficulties are manifested specifically through their voice makes the proposed warm-up phase all the more crucial to the process.

The use of breathwork in particular has been indicated extensively in the literature. Previous studies have discussed how shallow breathing may be the natural consequence of generalized or local muscular tension and may also be unconsciously employed by anxious clients as an attempt to control emotions. This often leads to an increased sensation of tension, anxiety and both physical and emotional rigidity (Austin, 2008). These in turn have been found to inhibit vocalization (Sokolov, 1981). Much has been written on the beneficial influence of

deep breathing on health, regarding in particular relaxation and stress response control. Many voicework pioneers specifically recognize the importance of breathwork and incorporate it in their therapies. The origins of Lisa Sokolov's (1981, 1987, 2009) vocal work yet began with breathwork for pain management and with psychiatric populations. Austin (2008) additionally describes using breathing exercises to help relax her clients and prepare them for vocalizations.

An understanding of the implications of vocal togetherness may be found as well in existing literature. Vocal interaction has been found to be one of the primary sources of bonding between the child and his caregiver is integral to the child's developing sense of self and ability to bond with others (Newham, 1994, 1998; Stern, 1985, 2002). The mother's vocal attunement and response to her child's vocalizations affect the nature of the bond and attachment formed between them (Malloch, 1999, 2009; Miller, 1981; Trevarthen & Malloch, 2000, Trevarthen, 2008). Stern's theory of affect attunement (1985) and of vitality contours (2010) describe the mechanism by which vocal and body gestures carry meaning in parent-infant communication. Throughout this primary communication, the affect of the infant's vocal gesture is ideally attuned to by his caregiver and expressed in a different form than the original. This natural and mostly unconscious occurrence forms the basis of the parent-child relationship. It additionally shifts the focus to the quality of the feeling being shared, promoting the infant's sense of self and a feeling of a common emotional experience. As in the child's primary relationship, the therapeutic relationship in this voicework model is underpinned by the nature of these vocal exchanges. In particular, the vocal attunement fostered in the vocal togetherness phase may serve to replicate the original parent-child vocal relatedness. Furthermore, the musical elements present in vocal interactions may form a container which promotes a sense of safety and decreased anxiety, essential to relationship formation and self-expression (Uhlig, 2006). It's therefore not surprising that the formation of such an attuned vocal relationship alongside the

intimacy generated by singing together appeared to hasten the cultivation of a trusting relationship and therapeutic alliance in the cases studied.

Though it is often an objective in voicework, the concept of vocal liberation is more commonly found in vocal training literature rather than in voice therapy terminology. Rodenburg (1992) has observed that "…nothing is quite so freeing and enlarging as a liberated voice" and writes of the restrictive tendencies of what she terms the "habitual" voice. Vocal liberation has been mentioned as well in Newham's (1999) work, in which he describes liberating the emotional expression of handicapped clients with neuromuscular constriction and of neurotic adults with muscular hypertensions caused by psychological inhibitions.

The therapeutic value of rhythm, the key musical element incorporated in the vocal structuring phase, has been previously established in the literature. Rhythm has been found to provide temporal structure through patterning, metrical organization and predictability, thereby regulating physiological and behavioral functions through entrainment (Thaut, 2005). Moreover, rhythm has been found to control the rate of speech and production of syllables (Healey et al., 1976). Thaut (2005) further suggests that the temporal structure provided by rhythmic engagement may enable the brain to organize feelings and reduce anxiety and fear, as well as induce feelings of safety. Uhlig (2011) has previously implemented this potential, giving order and structure to children at risk's overwhelming emotions through rhythmic rap singing in an attempt to regulate their aggressions.

The concept of using the voice as a primary instrument for emotional expression and catharsis was first described by the psychologist and voicework pioneer Alfred Wolfsohn (Braggins, 2012). A physiological basis was provided by medical doctors Heman-Ackah (2009) and Benninger (2010), who provided evidence of the voice's ability to express all human emotions, ranging from the greatest joy to profound sorrow. This appears to make the voice an ideal tool for therapeutic work.

The therapeutic use of vocal empowerment has deep roots. Songs and human vocalizations have been used as natural sources of encouragement and strength for centuries and throughout different cultures (Uhlig, 2006). Examples may be found in Native American chants, labor songs, sporting competitions and more. The inherent ability of songs and the act of singing to empower appear to make them a natural and potent source of reinforcement and self-assurance for the timid and anxious child.

The concept of vocal image has its foundations in voice therapy literature. Newham (1998) held the belief that the voice expressed and reflected personal identity and could as well aid in the actual formation of one's identity. More recently, Uhlig (2006) has written on the voice as an active agent who tells us who we are and how we feel at any given moment. Martin (2009), a speech and language therapist, yet described vocal sounds as unique vocal "fingerprints" that distinguish us from one another, but which may be purposefully or indirectly affected or shaped. In young clients suffering from anxiety issues, their emerging self-identity is often one of timidity, nervousness, uncertainty, lack of confidence, low self-image and/or reservation. This is often reflected through their vocality (or lack thereof). The voice may therefore potentially serve a crucial role in the formation of the young client's burgeoning personal identity.

The terms of vocal confrontation of fears and of vocal processing have not found to be previously mentioned in the professional literature.

This vocal model's contribution largely lies in its unique method of applying the aforementioned vocal terms and elements in therapeutic voicework with children suffering from fears and anxieties, in its therapeutic objectives to bring about both emotional wellness and vocal modification of the vocal manifestations inherent in this population and in its integration of various vocal concepts into a comprehensive voicework model.

Voicework Model Features

The voicework model proposed in this chapter is typified by the following characteristics:

Structure. As aforementioned, this model is organized into stages, phases and defined vocal elements which generally typify these phases. Phases are generally sequenced in a manner that prepares the client for each subsequent phase, thus advancing the therapeutic process. The role the voice commonly plays within each phase, whether "as therapy" or "in therapy", has further been identified and vocal elements have been categorized based on the degree of verbality and vocal improvisation they require from the client. These components have been suggested to play a role in the timing of application, either of vocal phases or of the vocal elements applied within these phases. This model may therefore be defined as a rather systematic and methodical one. The structured characteristics of this model contribute towards the formation of a comprehensive approach by which this model may be applied in therapy.

Flexibility. Despite its structure, the model proposed is a very fluid and non-formulaic one. When applying it in voicework with the population studied, the phases described in this work suggest a flexible structure for the course the voicework may take. As may be concluded from Figure 1 and Figure 2, these phases generally overlap, may be shortened or lengthened as deemed appropriate for each individual case and may have their components applied intermittently throughout different stages of therapy as needed. Vocal phases may even be omitted in some cases (such as the phase of vocal structuring in case studies 2 and 3) or be substituted for (as in vocal structuring replacing vocal liberation in Case study 1). Phases may also be incorporated in the voicework process outside of their customarily designated stages. This same principle of flexibility holds true within the vocal element category. Certain vocal elements may be absent from the therapy process (such as those of gibberish and animal sounds

in Case study 1) and vocal elements characteristic of later stages may appear in earlier ones and vice versa.

The number of sessions implicated for clients treated through this approach varies as well, in accordance to their personal attributes, treatment aspirations and complexity of diagnosis, among additional factors. The varying lengths of therapy processes evident in the case studies presented support this assertion.

Versatility.

In form. This model suggests use of the voice in diverse ways, exhibiting the voice's multi-faceted possibilities in the therapy setting. Nine divergent phases have been described which frequently characterize specific stages throughout the therapy process. These phases implement within them various vocal elements which may be applied in countless ways to achieve the therapeutic goals of each phase.

In multiple disciplinary integration. A variety of creative and expressive modalities were employed within this voicework approach to maximize its therapeutic potential and its adaptability to clients' unique and evolving needs. The modality most frequently integrated and fundamental to this model is naturally that of music in all its various forms, but mostly musical instrument improvisation. Among other uses, musical improvisation has been used to prompt vocality, to aid in anxiety reduction, to assist in client-therapist interactions, to provide rhythmic and melodic cues, to inspire and support in the release of diverse forms of vocality as well as to accompany and contain vocal expressions. Additional mediums incorporated within this voicework approach include movement, art, drama and songwriting. These modalities were often used together with the voice as an integral part of voicework techniques or were integrated within sessions to assist in voicework objectives, in insight processing and in progress summarization.

In treatment approach. The versatile use of this voicework model is employed to treat both vocal issues (which appear as a symptom of underlying emotional issues manifested through the voice itself), as well as to promote the expression and treatment of underlying emotional issues. The model described thereby seeks to target both emotional and vocal goals. In all case studies researched, the emotional pathology involved was expressed through the client's voice and was treated accordingly through the voice. Treatment related to the vocal aspect of the presenting difficulty alongside the underlining emotional aspect, thereby focusing both on vocal goals and on emotional goals, often simultaneously. These goals correlated with each other both in expression and in treatment. Therefore, treating vocal issues often resulted in an expression and resolution of the underlying emotion issue, and treating emotional issues through voicework often resulted in corresponding vocal modification.

Some examples of this approach, previously described in the case studies, are summarized in the table below (Table 4):

Table 4

Examples of Vocal-Emotional Work in Case Studies

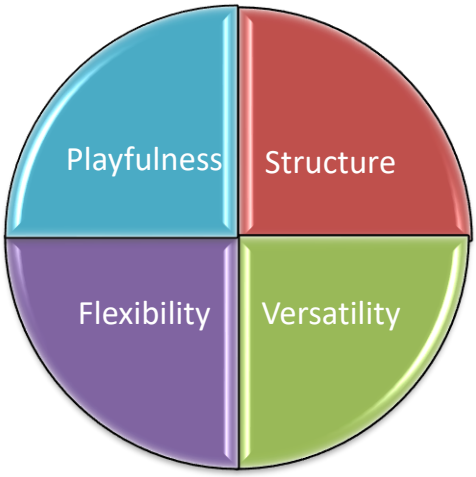
Client	Vocal symptom	Vocal goal	Emotional goal
Shira (Case study 1)	Shouting speech	Moderating vocal volume	Accepting the quieter, more subdued parts of Self which were attributed to fear and sadness
	Stuttering, disorganized speech	Organizing speech-regulating fluidity, tempo and rhythm	Reducing anxiety while promoting relaxation and sense of control
	Avoidance of crying	Vocal expression of emotions viewed as negative or anxiety-provoking	Reducing anxiety of touching upon various emotions while legitimizing and containing expressions of sorrow and fear
	Avoidance of talking about fears	Triggering speech on taboo topics by first expressing fears through alternate, less inhibited channels of vocality	Releasing emotional expression and opening a dialogue concerning fears
Noa (Case study 2)	Vocal tic	Fluent and emotive vocal expression	Release of underlying tension and strong emotions viewed as threatening or forbidden
	Wavering "nervous" voice and outbursts	Stable and controlled vocality	Promotion of self-soothing abilities and emotional regulation
	Vocal split between two opposing voices	Vocal integration of split	Acceptance and integration of varied parts of Self, improving self image
Leah (Case study 3)	Selective Mutism	Release of vocal cord tension, liberation of voice from constrictions	Decreasing social anxiety
	Whispering speech	Increasing vocal volume	Lowering inhibitions and increasing self confidence
	Monotonic speech	Pitch variation and vocal expressiveness	Release of emotional rigidity and tension
	Lack of vocal assertiveness	Vocal expression of anger, vocal confrontation	Acceptance and reduction of fear of own feelings of anger

Playfulness. Play in its various forms was proven to be an essential component involved in each voicework process examined and in every phase aforementioned. Most of the vocal applications employed play as a key component. Some of the vocal elements themselves may even be considered "playful" such as animal sounds, gibberish, and primary sounds. Moreover, all vocal elements were incorporated into therapy in a playful manner and through playful interactions, promoting the pleasurable, uninhibited use of vocality. This approach proved especially useful in gaining cooperation from the population this model is intended to treat, as play is a medium through which children naturally and unreservedly express themselves. Paired with a child's innate use of vocality and the enjoyment typically derived from it, this union of play and vocal use, which I term "vocal play", proved particularly effectual when incorporated in therapy. Moreover, playful vocal interactions were found to be especially beneficial in the treatment of fears and anxieties, as this form of interaction is reminiscent of a child's earliest form of communication with its primary caregivers. As such, it is conducive to contributing to a close, trusting relationship with the therapist and in creating a familiar, relaxed, non-threatening environment. Such an atmosphere and therapeutic relationship allow the emotional issues surrounding fear and anxiety to be touched upon and expressed. The use of vocal play subsequently aids in loosening up physical and vocal restrictions, thereby freeing the voice's expressive potential and innate tension-reducing potential. The title of "VocaPlay Therapy" therefore seems appropriate for the model thus far developed.

To summarize, this model of VocaPlay Therapy may be defined as a flexibly structured, versatile, and playful voicework model for the treatment of fears and anxieties and their accompanying vocal manifestations in children. These defining features are illustrated in Figure 3 below:

Figure 3

VocaPlay Model Features



This model of VocaPlay Therapy serves as a foundation for the following cycles of this study. The main research questions in Cycle 2 were: What are experienced music therapists' perspectives, impressions, and observations regarding the model formulated in Cycle 1? Is the initial model appropriate for children with fears and anxieties? How may the initial model be developed and improved? What factors may facilitate or hinder music therapists' use of the model? Who is the therapist best suited to incorporate this model?

In this cycle, I interviewed five experienced music therapists whom incorporate the voice in their practice on their impressions, thoughts and ideas regarding the voicework model developed in Cycle 1. The model was depicted to each interviewee via a summarizing video presentation which was produced especially for the sake of the present study. Participants reviewed the presentation prior to the interview. Interviews were audio-taped and subsequently transcribed. This cycle formed a basis for the attunement, refinement and development of the original model. Furthermore, the process aided in introducing insights and queries raised by the participants, which were further explored in Cycle 3.

CYCLE 2

Method

Participants

Contributors were selected to participate in this cycle through homogeneous sampling (Patton, 1990). They included five female music therapists who administer therapy in Israel, most of whom additionally specialized in the field of movement therapy. These therapists had an average experience of over 15 years in the field of music therapy. All had backgrounds that included either voice development lessons, choir participation, vocal improvisation courses and workshops or all of the above mentioned. Additionally, they all had some degree of experience working with children and/or youth suffering from fears or anxieties. The amount of vocality generally incorporated in their therapies varied from client to client and throughout therapy processes. Influencing factors included the participants' perception of their clients' willingness to use the vocal modality and the therapists' personal vocal inclinations and previous voicework training. Most of these participants reported incorporating voicework in their therapies on an "as needed" basis, as an additional treatment modality secondary to music therapy or to music & movement therapy. Even when voicework was used by them as the primary treatment modality, it was nearly always accompanied by music. Voicework was mainly incorporated in therapy by these participants through the singing of pre-existing songs, either by the therapist, the client or by both. These songs were either musically accompanied by the therapist or sung to a pre-existing accompaniment. Vocal improvisation and dramatic use of the voice in a story or play were also techniques mentioned by some participants.

Tools

Data was collected through questionnaires (Appendix F) and through partially structured individual interviews conducted in Hebrew and generally consisting of fourteen key questions (Appendix G). Interviews included questions such as: What were your impressions

of the voicework model? How suitable do you think it is for treating children with fears and anxieties? What would assist you in implementing it in your work? These questions were based on the viewing of a video presentation of the model initially developed in Cycle 1 (spanning over 45 minutes). This video was specifically produced for the sake of this study and reviewed the foundations of the VocaPlay model (in Hebrew), alongside clinical audio taped vocal demonstrations.

Procedure

Following the signing of an informed consent form (Appendix E), participants were first given an initial questionnaire to fill out regarding their professional and vocal backgrounds as well as their use of vocality in the therapies they administered (Appendix F). They were then asked to view the video summarizing the model established in the previous cycle which included audio demonstrations. Participants were subsequently interviewed on their impressions, thoughts and ideas regarding the voicework model through a partially structured interview. Each interview was audio recorded and subsequently transcribed (available upon request).

Analysis Method

Filled-out questionnaires and interview transcriptions, spanning over 50 pages, were analyzed using interpretative phenomenological analysis (IPA) (Smith & Osborn, 2003). The analysis included the following stages: Transcriptions were read numerous times in order to familiarize myself with the material and then notes were written in the margins pertaining to my understanding of the arising material. A phenomenological perspective and interpretative perspective was noted alongside participants' contributions. The unique circumstances surrounding each participant’s voiced opinion was taken into account, including their background, personal experience, training and vocal condition. I then combined the notes of all discussions pertaining to each topic into a list of rough categories. Subsequently, I searched

for distinguishing features as well as commonalities in the experiences and thoughts mentioned under each category, or meaningful relevant segments of data. I then labeled the meaning units and group similar categories under one label that I felt described the entire group. Significant themes that emerged were used to attempt to draw conclusions regarding various aspects of the voicework model that evolved through Cycle 1. The information that emerged from this cycle served to advance the inquiry by considering the perceptions, thoughts and assessments of the participants in relation to the voicework model proposed.

Ethical Issues

As aforementioned, the entire study (including this cycle) was approved by the ethical committee of the Music Department at Bar-Ilan University (Appendix B).

Client confidentiality was observed at all times throughout this cycle. No identifying personal client information was revealed in the video presentation viewed by participants and consent from clients' caregivers was obtained to include audio demonstrations in the presentation. Additionally, participants were required to sign an informed consent form which including a clause prohibiting the distribution of the video and its contents. Colleagues were guided to conceal the identity of their own clients during interviews, referring to them by pseudonyms and obscuring any identifying personal information. The identities of contributors to this cycle were concealed. They were referred to by pseudonyms throughout this work and will remain strictly confidential.

Trustworthiness

Precautions were taken to ensure the integrity of this research:

1. Triangulation, involving the use of different data collection strategies throughout the research, was used to this end. The methods of questionnaires and individual interviews employed in this cycle are prominent in much qualitative research and add to the strategies used in the previous cycle, which included clinical

documentations of therapy sessions, observations, case studies, audio recordings and clients' concrete products from therapy sessions. The use of different methods within the study may compensate for their individual limitations and exploit their respective benefits (Brewer & Hunter, 1989).

2. In congruence with the study's methodology of AR, this cycle allows scrutiny of my viewpoints, assumptions, conclusions, and course of action by colleagues and peers. It makes possible the ongoing refining and testing of the studied model with the active assistance and participation of co-researchers, in response to their perspectives, experiences, and observations. This course of action contributes to the study's subjectivity.
3. Member checking (Lincoln & Guba, 1985) relating to the accuracy of the data gathered was ongoing throughout this cycle. Participants were asked to read and to corroborate transcripts of dialogues in which they participated and to consider if their audio recorded words matched their intentions.
4. In regards to transferability, detailed descriptions of all occurrences and background data will be provided within the study to establish its context and the study's limitations will be made clear, in order to allow comparisons to be made to this study's findings in future research done on this topic.

Findings

Seven main themes and twenty sub-themes were identified through interpretative phenomenological analysis of the materials. The main themes include: Incorporation of existing voicework models with children, principles considered important in treating the studied population, perceptions of the proposed voicework model, considerations regarding the therapist to incorporate the model, the therapist's use of her voice in therapy, factors influencing

the therapist's potential use of the model in her work, and the integration of additional creative modalities in the model.

1. Incorporation of Voicework Models with Children

None of the participants incorporated any specific existing voicework model in their therapies with children, claiming they knew of none that were relevant for their work with this population. Lacking a vocal model to refer to in these cases, they tended to mostly rely on their intuition ["Whatever comes naturally…" -G, "Not in an orderly manner but as something intuitive"- A.], prompt vocality through movement and dramatic play or to attempt to transfer techniques used with musical instruments to their vocal work. Unless participants specifically defined themselves as voicework therapists, they didn't tend to specifically direct the therapy they facilitated towards voicework or to otherwise focus on the child's voice in their therapies in any systematic, continual way that would constitute a process in itself. Vocality was usually incorporated in their therapies as secondary to work with external musical instruments.

2. Principles in Treating Studied Population

2a. Treatment of children in general. Beyond those applicable to therapy with all age groups ["…first of all truly being with the client and trying to see what is right for him, respecting him and valuing him". –E.], principles considered to be of special importance when working with children were: Flexibility within the therapy sessions alongside the ability to set clear and firm boundaries, the incorporation of playfulness and imagination in the sessions, the facilitation of self-expression and the promotion of self-awareness. It was suggested that children's therapies be experiential with the possibility of working indirectly on the issues at hand. It was emphasized that the therapeutic experience must always be shaped in accordance

to the emotional and cognitive level of child being treated as well as adapted to his[3] individual needs.

2b. Treatment of children with fears and anxieties.

The therapist's role. It was deemed important that the therapist working with such a child be capable of maintaining patience throughout the process and that she convey: "…much confidence, calm and a sense of being in control in order to sufficiently contain the child's anxiety" -M. It was emphasized that the therapist should always be supportive of the child, while containing and legitimizing his feelings and reactions pertaining to fears and anxieties.

Self-awareness and the ability to remain calm and collected in the face of the client's anxiety was thought to be essential in treating such children, due to the often infectious quality of anxiety with its potential to transfer to the therapist and overwhelm her: "An anxious child makes you yourself very anxious very quickly. It's very contagious…" -M.

This being the case, the therapist must be keenly aware not only of the child's reactions, but of her own. She must be able to identify anxiety in her client and in herself, set inner boundaries and remain grounded in the face of anxiety.

Furthermore, it was considered important that the therapist administer parental guidance as well as supervision of the staff of the educational or health facility in contact with such a child (-E., T.).

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[3] *The pronouns "he" and "him" will be used in this study to refer to children of both male and female genders.

Session structure. An emphasis was put on maintaining a consistent therapeutic setting and on working and progressing gradually, according to the rate of the specific child being treated. It was also suggested that the sessions contain structure, clear boundaries and an element of repetition or familiarity (especially in the initial stages), thereby promoting a safe environment.

Session content. Incorporating relaxation techniques and aiding the child in self-regulation and in relaxing in general were thought to be essential. To this end, various relaxation techniques were mentioned by participants, including: Awareness of body, breathing exercises, imagery techniques, flexing and relaxing of muscles, work surrounding finding a "safe place". Instilling in the child a sense of control during the sessions, particularly over his fears, while promoting release, creativity, self-reflection and confidence, were also noted. Work on personal boundaries was also believed important (-G). Suggestions additionally mentioned were allowing the child to express his fears and anxieties, while promoting awareness of his thoughts, feelings and reactions and gradual exposure to source of fear. Finding ways to incorporate concreteness in the sessions, such as through visual products, was thought to serve as an anchor for anxious children, further calming and reassuring them: "Especially with anxieties, there is something very calming in concreteness- a type of anchor." -A.

2c. Voicework in the treatment of children with fears and anxieties. In the case of some vocal and speech disorders, voicework was considered to possess the unique additional advantage of promoting vocality as well as expressive speech, allowing these clients to actually voice their fears and issues. Furthermore, an emphasis was put on the possibility of advancing the client's awareness of his speech and vocality, particularly aspects pertaining to vocal volume which are often affected in those with fears and anxieties and on gaining control and even altering these through voicework. The significance of the therapist

"giving voice and listening to even the smallest of voices" (-G.) was additionally noted. Voicework was thought to contain the potential to hasten and promote the therapeutic process ["it jump-starts the client's progress." -T.]. It was thought to do so by promoting intimacy and closeness in the therapeutic relationship, touching directly upon issues at the core of anxieties, and by liberating emotional expression and deepening the connection with one's self. All these were considered significant advantages when used sensitively and appropriately in the therapy setting.

Alongside these perceived benefits, participants also voiced concerns that at times, particularly during the initial stage of a therapy process, the voice may be experienced as revealing and exposing by certain clients: "…it's something very deep, real, 'me', to bring myself. An anxious person is not always at that place." –E. This concern often led them to incorporate voicework very cautiously with children, often opting to begin with other treatment modalities deemed more "familiar" to their clients: "When I work with anxious children I first try to help myself by beginning in a safe, familiar, obvious place"-G. Likewise, they tended to limit vocal interventions to those considered more conventional (such as singing known songs to or with the client).

3. The VocaPlay Model

3a. Impressions. Participants felt that the vocal model presented filled a void for them regarding voicework possibilities with children and raised awareness of the therapeutic possibilities, significance and usefulness inherent in voicework with children: "It seems to me very important. It's something that is absent (in the music therapy field)." –E.

It was also thought to be a unique addition to the field of music therapy, facilitating work on the voice through emotional aspects and vice versa. The model was described as: well thought out, useful ["It gives me tools. It opened my eyes to where I am, at what stages and with which patients…it is very useful" -T.], very practical ["…it's very much related to the

practical world of therapy and is based on things from the field." -M.], encompassing ["It's very detailed", -T.], thought provoking, methodical, comprehensive albeit complex ["It succeeds in being complex and also very clear"-G.], thorough and elaborate ["…many different uses of the voice, many different stages, a variety of vocal techniques." -M]. It was thought to be flexible with much freedom in application, yet concurrently very structured and organized.

Many participants found the model to be very measured, gradually and sensitively exposing the client to the use of voice, while also guiding through phases in the therapy process is a very steady manner: "The exposure (to vocality) is gradual and adaptable, not invasive." -A. This quality of gradual progressiveness was also thought to assist in learning the model, as it structures and organizes the vocal work in a systematic manner: "The structuring helps organize the conduction (of the therapy) and the understanding of it for us…it gives (the work) more depth and gives us more tools"- A. Overall, the model was thought to be attuned to the client and to his or her needs.

3b. Relevance. The model was viewed as important for music therapists as participants reported coming across many children with vocal issues during their work and feeling that they did not have the training necessary to treat such issues:

> "I think it's very important for a music therapist to work on the voice and it's not only the role of speech therapy. It is worked on differently (in the model), through the emotional place…it's important because we do come across, I personally come across, everything you mentioned: Selective mutism, stuttering, babyish voices…"- M.
>
> "I don't think the existing voicework models are for children, and I mainly work with children." -T.

Participants also commented on the fact that many children that come to therapy have fears or anxieties, making it useful and important in their opinions to have a model to work with them. The model was additionally thought to be useful in assisting therapists who are interested in

working with children through voice and don't know how or where to begin or how to progress within such a therapy: "I think that maybe it would be good for therapists to have some things in hand, techniques, things that may assist, which is what you are doing." –E., "It (the model) being systematic and structured can also help therapists who want to work with the voice but don't know where to begin."-G.

3c. Presentation. Many participants enjoyed hearing and experiencing the vocal model through the video presentation: "It was really interesting to hear and to experience it through the presentation…It was very gradual, very structured. It calmed me…" -A.

Vocal demonstrations within the presentation were said to have left a strong impression. They were found by the therapists to be especially helpful in understanding the applications of voicework throughout the models' phases, and as such were thought to be an efficient teaching tool: "The thing that was most powerful and significant for me was the (vocal) demonstrations. That was really potent, important and educating." –E., "I heard the demonstrations in the video and then suddenly realized- 'ah, it could work for this client (of mine)', and then I applied it…" -M., "It (the demonstrations) opened my mind." -T., "I could see how significant it (vocal play) is in therapy and how the child succeeds in progressing through it…" -M.

The aspect of visual concreteness in this particular form of presentation was also thought to aid in the learning and understanding of the model: "There is something in the concreteness that helps a lot because this (voicework) is an experiential art that is transient." -A.

Disadvantages of using the video pointed out by participants were mainly that it did not demonstrate the integration of additional modalities inherent in the model such as movement and visual art and that much information was packed into a (relatively) short presentation, not allowing for sufficient elaboration.

3d. Suitability to the population studied. Overall, the model was considered to be well suited to the target population of children with fears and anxieties. Many even felt that playfulness and creativity, which were viewed as key elements in the model, were goals in themselves in the treatment of anxious children and that vocality was a valuable tool in achieving them: "That is most definitely the goal in my opinion with anxious children-playfulness. Really "the" goal and (the model) is a really wonderful way to accomplish this." -G.

The model was thought to incorporate varied aspects viewed as fundamental in the treatment of fears and anxieties. These included allowing the therapist to cradle, hold and contain the anxious child as well as accompany him throughout the entire process through vocal mutuality. Promoting interaction, mutuality and togetherness in the child distanced by anxiety by having the therapist actively participate and accompany him vocally was an additional aspect mentioned. Also noted was counteracting the constriction and paralysis anxiety may invoke by advancing flow and release through wind instruments ["…suddenly this use of wind instruments brings out of the child something which is extremely flowing and fluid." -G.], and vocal expression as well as promoting expression of emotions, creativity and "vocal movement". The later concept related to the investigation and expansion of vocal and expressive possibilities throughout the model. Additionally, connecting the client to his or her body through breathing ["The breath reconnects us to the body." -G.] and vocal production were considered important in anxiety since there exists is a tendency to disconnect from one's body. Vocal improvisations as well as vocally directing or re-directing the client were viewed as means to setting boundaries and giving framework during sessions. The gradualism inherent in guiding clients throughout phases, uses of vocality and exposure to fears and in the encouragement of verbality and processing were also viewed as essential in the treatment of anxious clients. Facilitating therapy in a playful and creative way and permitting indirectness

by "expressing through the voice things that may be difficult to express through words" (-G.) were also among these factors. Additionally mentioned was the promotion of acceptance of self in the client through the acceptance of his voice by both himself and by the therapist witnessing his process: "The child accepts his voice through the different voices that came up throughout the therapy and you're entirely there with him because you went through this process with him." -G.

Noted as well was the advancement of dialogue among different aspects of the client's personality. Empowering the timid, unconfident client and advancing assertion in him were also viewed as essential factors. Finally, the model was thought to make work on fear and anxiety, which can be difficult for the client: "…playful, interesting and enjoyable." -M.

There were conflicting opinions on whether applying the model with a closed, rigid child or one severely lacking in creativity and playfulness would likely prompt and develop the traits lacking in him or conversely arouse hesitation and lack of cooperation from him: "You need a certain openness to work with voice and readiness for something that may be very exposing. Something very primal. Something very real." –E., "In children with fears or anxieties there may sometimes be some emotional blockage that causes the child to resist doing things that require creativity from him…" -T.

Similarly, some raised the question of whether focusing on vocality, an aspect often directly affected by the client's anxiety, may be difficult at first or even arouse his resistance: "I think there is something very direct in voicework... we can't always immediately touch." -E.

Others expressed the belief that it was precisely the concept of working directly through vocality on the child's affected vocality that made it a powerful and effective [4] model: "It (vocality) can connect to one's self, can help express..." -A., "It may shorten processes." -M., "The topic of exposure…with clients it is usually the main issue, so it may be best worked on directly through vocality." -T.

Additionally, it was suggested that children who don't feel connected to music or to vocality may need either an extended pre-vocal phase or to begin with something closer to their areas of interest. Children who tend to use vocality in a restricted, limited manner may need a way to bridge what they are already familiar with to other more novel options: "I must find the bridge between the obvious, natural use the child does with vocality and the less familiar, more creative use." -G.

To this end, the pre-vocal phase was often viewed as contributing in aiding children to progress to the model's more advanced phases: "I will apply this phase often in order to calm and reduce the client's tension in the beginning and then afterwards it may be easier for him to flow with the creativity." -T.

Importance was placed on how and when the model was applied with a client ["It really depends on how it is used." –A.] and on the therapist's adjustment of the model for the particular client being treated: his personality, needs, emotional stage, personal progress rate and his relationship or dynamics with the therapist. It was additionally mentioned that not every child may be able to progress through all the phases and stages of the model, and that: "For some,

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[4] It should be noted that the terms "effective" and "efficient" are used throughout in this paper to describe a general feeling that the model may promote or benefit the client. They are not intended to hold the meaning related to their use in positivistic research.

certain phases may be sufficient for their current emotional, cognitive or developmental state." -T.

3e. Suitability to additional populations. The possibility of the voicework model being compatible for work with additional age groups and populations was also suggested by many of the participants: "You limited it (the model) when you said it was for children with anxieties…because many things you wrote seem appropriate for way beyond…." -E., "There is something in the gradualism (of the model) that may be suitable to many forms of work. Every client can take it to a different place, but the goals can be fitting."-A.

Among those mentioned were age groups of youth and adults with anxieties (if appropriately adjusted) were mentioned, vocal issues and disorders among the general population ["It may be suitable for patients who have certain problems with their voice."- M.] and children with additional difficulties, for which certain phases may be borrowed: "I think that at some stage this model can suit everyone, meaning all normative children that have some difficulty that they need to deal with". -G.

Examples given of such children included: emotional regulation and control issues, behavioral problems, ADD/ADHD, introversion, emotional expression, rigidity and children who need to learn how to play. Though the model was believed to be best suited for verbal children, it was suggested that parts of it, especially the initial phases, may also be successfully employed with non-verbal or cognitively impaired clients, either with or without anxiety.

3f. Applications. The model was thought to be very useful for therapists and different modes of incorporation were suggested by participants, largely based on the model's flexibility: "I think this model contains the possibility of systematic work… but also something very flexible that you may take some of this and some of that and combine. I think it's an advantage that this model has. You don't need to use all of it all of the time." -G.

Recommended uses included: systematic voicework incorporating the model in its entirety, applying only specific phases as needed as using all phases was not considered always necessary (phases were viewed as potential processes in themselves), integrating voicework phases or stages into another or perhaps pre-existing process as needed thereby enriching work already being done by the therapist and borrowing ideas, tools, concepts or techniques from the model as needed and spontaneously incorporating in all therapies when deemed appropriate. This final option contributes to expanding the therapist's toolbox and makes aspects of the model accessible to many therapists and even to those in different disciplines: "It may be a secondary tool for other therapists but still assist them." -T.

4. The Therapist

4a. Professional orientation. The model was considered most appropriate and natural for music therapists and voicework therapists to apply, as "music is the language of the therapy" -E. Such a therapist would be most aware of whatever might arise through the vocal expression of the child and know best to make use of it, as well as understand the meaning of the musical elements inherent in vocal use. The possibility of therapists from additional fields incorporating the model was discussed. It was proposed by some that any emotional therapist that feels comfortable with her voice and with using her voice in the therapies she administers may be a candidate for using this model. At the very least, such a therapist may: "…implement aspects of the model and techniques in their therapies, just as music therapists implement other modalities as needed." -A.

In this manner, the vocal model may be used as a major tool for music therapists and minor tool for other therapists. This was believed to be particularly relevant to psychodrama, movement or play therapists. It was suggested that a specialized course on the topic may assist such therapists in best applying the model.

4b. Professional experience. The model was believed to be appropriate for any music therapist, regardless of experience in the field of music therapy. For experienced therapists, it may open their mind to a different way of thinking and working, expand their therapy tools and enrich their therapies: "It's good for experienced therapists to learn something new…it may enrich anyone's therapies". -M. For beginning music therapists, the model was regarded to possibly be of special importance: "Especially in the beginning…to have a model that organizes and clarifies the uses of voice in therapy." -M.

This was thought to allow them to work with increased confidence. In cases where the voice is the beginning music therapist's personal instrument, the voicework model was thought to potentially be an even more appropriate system for them to begin with than models incorporating the use of musical instruments in therapy: "Those who are very connected to their voice and have a healthy relationship with their voice may use it (the model) even immediately, sometimes even before musical instruments in therapy since the voice itself is considered an instrument." -T.

Those who don't possess vocal abilities may certainly learn the model, experience and practice it and then gradually apply in their work according to participants. Supervision of the work of therapists incorporating such a model was considered to be necessary, especially for beginning therapists. It was further suggested that learning a model such as this one during beginning stages of the music therapist's training may turn the use of voicework by music therapists into: "…far more common and accessible to them." -M.

Additionally, it may assist music therapists in becoming more comfortable and confident in using their voices in therapy in general:

> "Many more therapists might feel more confident using voice in therapy and comfortable with it if they were to learn such a model already from the beginning. It

opens possibilities and gives very important tools for work. It would have very much helped me." -M.

4c. Personal traits. Beyond possessing the attributes vital to any therapist, such as attentiveness and attunement to the client, alongside good judgment of which techniques to use with which clients and at what timing, implementing the vocal model was thought to require creativity, playfulness, flexibility and mostly uninhibited vocal expressiveness from the therapist: "If the therapist comes empty without these abilities, then there can be no therapy… it's like planting these things in the children and then watering." -M.

Having a healthy relationship with her voice and being connected to her inner, authentic voice were said to be key: "She should feel connected to her voice and comfortable with it in order to use it for the benefit of the therapy." -T.

Additionally, acceptance of her own voice and of the clients' voice while adopting a nonjudgmental and non-critical attitude towards both was considered essential. The therapist must also feel comfortable with the exposure and intimacy created by incorporating her voice in therapy and in using it to treat another's voice: "I feel that the therapist should be vocally liberated in order to work with the child's voice." -T.

4d. Vocal background. It was thought that therapists should undergo vocal workshops, voice development lessons or have personal experience in some framework of vocal work before learning the vocal model. It was further recommended that the therapist using voice as a therapeutic tool undergo a personal process of voicework therapy to experience such work firsthand and perhaps address some of their own vocal issues: "Personal experience (in voicework) may contribute a lot." -T.

4e. Vocal abilities. It was agreed among all participants that the therapist using this model should have the vocal ability to use her voice in various forms of voicework. She must be capable of vocal release and of using her voice freely and in an uninhibited, liberated manner

to encourage her clients' use of vocality, to legitimize their use of vocality and to model therapeutic uses of the voice during sessions. She should have: "…the ability, confidence and vocal control to vocally improvise just as the music therapist must have the ability improvise on musical instruments." -T.

The voice should be part of such a therapist's easily accessible toolbox. However, it was not thought necessary that the therapist be a professional singer or possess outstanding technical vocal abilities, and was even suggested that such abilities may prove threatening to the client or inadvertently create a situation in which the client might compare his abilities to those of the therapist: "You don't need to be a singer to use it. On the contrary, sometimes that may be threatening or encourage comparisons."-A., "The client may think 'why can't I succeed as well'?" –E.

That said, the therapist's level of comfort with her own voice, with incorporating it in therapy and having it heard by her clients was thought to be far more important than her actual vocal abilities: "A therapist that uses vocality should feel comfortable with his own voice… some degree of easiness, of certain freedom, "good enough", a tool she can easily pull out. Something she feels comfortable using." -A.

It was further feared that a therapist that feels uncomfortable with her own voice might inadvertently send conflicting and contradictory messages to the client: "If the therapist is embarrassed of his voice and so decreases its volume…and the client picks up on it then the message sent is the exact opposite of what we want to relay." -G., "In order for the therapist to be in a place of vocal containment, she must herself feel comfortable enough with her voice to contain another's…" -T.

5. Therapist's Use of her Voice

5a. Inhibiting factors. The notion of employing voicework in their therapies brought up participants' fears and anxieties regarding their voice. Many reported feeling uncomfortable, inhibited and insecure in using their voice in therapy, or unable to sufficiently release their voice: "I feel I need to work on releasing my voice more in therapy." -T.

Some felt exposed or overwhelmed when using their voice: "…it's too exposing (singing in front of others), too frightening, too powerful, too penetrating, too much!" -M., "The issue of exposure is not always easy for me." -T.

Others were specifically not at ease with the intimacy vocal use may create in therapy, as sharing one's voice with another was experienced as very personal:

> "The voice is the most personal thing and voicework- using your voice to treat another's voice- creates tremendous intimacy… I cannot give my voice to somebody else. It's MY voice- it's very embarrassing… I'll be able to use my voice when I overcome all my intimacy barriers." –M.

Additionally, fear of the client's criticism and their own self-criticism towards their voice arose:

> "If I would do it (use voice) with a normative child I may immediately enter a judgmental place…that would cause me to recoil or to think twice before I begin" -G.
>
> "If I have a client whose ideal is Sarit Hadad [a very popular Israeli singer with a Middle-Eastern vocal style and very developed technique] with the vocal trills and I have the smooth, operatic voice, I obviously don't feel I have anything to give him. I won't sing because I will be embarrassed of my voice, that it is not what he wants, so he'll be disappointed." –M.

Moreover, for female Jewish Ultra-Orthodox music therapists the controversy of singing with male children above a certain age was an issue discussed[5]. Even those who did receive approval from their Rabbi to use their singing voice in such situations didn't always feel comfortable doing so or weren't certain how their clients felt with it: "It still raises an issue; it's a topic in the (therapy) room and even if so, then how does the client feel with it…?" –E., "It still embarrasses me to sing before them (the male clients)." -M.

Many admitted to remaining in a place of comfort, safety and security themselves within the therapy session. When faced with a child who refrained from using vocality, many therapists tended to refrain along with him: "They avoid (using vocality) and I avoid with them." -G.

Most restricted themselves to techniques familiar to them that they felt confident in their knowledge of and ability to apply, and to mediums of expression they felt were most familiar to the client. Some were uncertain of how to employ voicework in their therapies beyond the obvious use of the voice to sing songs. All the above-mentioned factors were found to be chief vocal inhibitors.

5b. Enabling factors. Confidence in vocal abilities such as using the voice flexibly and appropriately in different situations was a factor that was reported to positively influence the therapist's use of her voice in therapies. Awareness of the contributions and importance of voicework to the therapy and its various possibilities was also noted. This was not always readily apparent to participants where children with intact verbal abilities were concerned.

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[5] Jewish law prohibits a male above the age of 13 to hear a woman other than his immediate family sing, as a woman's singing voice is considered sensual and possibly stimulating to males.

Furthermore, participants claimed they would be more likely to increase their use of vocality in their therapies if they had a technical anchor, such as a relevant structured and organized voicework model to refer to or a toolbox of vocal techniques that were readily available for their use: “I think that when it's more structured and organized it gives more ideas. Technical anchors can help." -A .

Furthermore, having a model to refer to was said to instill confidence in the therapist: If I now had a theory that I could point to and say 'this is the right thing to do because it is therapeutic', I would do it." –M.

6. Factors Influencing Potential Use of the Model

Beyond breaking free of their own vocal rigidity and insecurities regarding their voice ["…maybe I need to dare more, maybe this model tells me 'try more'…."- E.], having a concrete and comprehensive written model to refer to as well as being exposed to it in as many and varied ways as possible were considered key to the participants' incorporation of the model: "Even the video presentation already clarified things for me…focused things. Then it's possible to work with it." -A.

Further examples given of exposure included: reading case studies, receiving professional training, listening to vocal demonstrations, voicework simulations of different techniques ["experiencing them, playing with them, testing them on ourselves..." –E.], learning how to apply it in different ways and situations as well as receiving clinical supervision on their application of the model ["Experiencing all the different possibilities gives tools" -T]. Having the model readily accessible and simple to apply was further mentioned: "Making it more accessible. If it's more comfortable, a language that is developed, I'll also have more confidence to develop it myself." -A.

Additionally, achieving flow and spontaneity of facilitation through practice as well as gaining experience in introducing more creative, less familiar uses of voice in the therapy were aspects mentioned:

> "The more it's practiced with clients the more natural it becomes to incorporate it in therapy and less calculated. It becomes more fluid, more spontaneous. In the beginning you must be outwardly focused (on learning techniques) and then you can slowly introduce you own personal flavor and style (in the work). In the beginning, it's always best through professional training" -T.

Awareness was also considered an influencing factor: awareness of the model throughout therapies, of the child's vocality during sessions and of the potential impact of vocal play: "When you work with a child who is very verbal and who tells stories it is so easy to forget (the importance of vocality)" -G.

Working with a child who gravitates towards vocal work was said to further prompt therapists to employ the vocal model.

7. Integration of Additional Creative Modalities

7a. Movement. The importance of integrating movement within the model was greatly emphasized as it may also be considered a child-friendly medium, may assist with muscle tension and may promote release and awareness of the bodily sensations that accompany anxiety (-G.). It was further suggested that movement may complement the vocal work as sounds frequently accompany movements ["You cannot make a movement without making a sound together with it…" -M.], and it may serve as a diversion from feeling exposed within the vocal work (-A.).

7b. Music. The musical instruments viewed as most significant in therapeutic work with the fearful and anxious child in general were those capable of lending themselves to giving shape, order and harmony to sounds in general and to sounds vocalized by the child in particular

(-M). Instruments omitting a sound with a calming, soothing quality such as the harp, autoharp and guitar were thought to prompt and to support a similar quality in the client's emotional experience and in his vocalizations, thus potentially comforting and benefitting the anxious client (-T.).

7c. Art. Integrating art in its various forms in the voicework process was thought to be of value for the anxious client by serving as an organizing agent for his vocal work throughout the sessions (-G., A.). Producing a concrete product related to the process (such as a written song or drawing) or having a tangible outcome that the client could refer to was believed to further contribute to the voicework method. It was thought to do so by instilling confidence in the client and by providing him with a form of visual feedback (-A).

7d. Drama. Participants reported finding dramatic play, role playing, storytelling and symbolic plays useful in encouraging varied vocality alongside movement in their clients. This vocality included vocal sound effects, fighting sounds and altered voices to fit the characters portrayed: "It adds to the release and enjoyment of playing." -M.

Discussion

Based on this cycle's findings, the following conclusions were drawn and modifications made to the voicework model considered.

Suitability to Studied Population

Voicework with the studied population was perceived to possess the potential to promote intimacy and closeness in the therapeutic relationship, directly touch upon issues relevant to anxieties and liberate emotional expression. This model was found to incorporate varied aspects viewed as fundamental in the treatment of fears and anxieties. It was additionally thought to make work on fear and anxiety, which may be difficult for the client, playful, interesting and enjoyable, thereby encouraging client cooperation. It was also found to meet many major criteria found to be essential in the treatment of the population studied in regards

to session structure, session content and its suitability for children. Following participants' observations, the structure of the therapy session in the model will be modified to emphasize the necessity for clear boundaries throughout sessions. Furthermore, the session content will be revised to include the additional elements of repetition and familiarity. These were believed to contribute to work with children with fears and anxieties, especially in the initial stages of the therapy process.

Concrete products and visual aspects inherent in the model, including artwork, composed songs, visual and auditory feedback, as well as recordings of the vocal creation will be further emphasized in future presentations of the model, as the element of concreteness was believed important in calming and grounding the anxious client, serving as an anchor in therapy. The role of musical instruments in this voicework process to either calm the client by adding shape, order and harmony or to assist in the expression, release and catharsis of fearful emotions will as well be further accentuated.

Usefulness

Overall, the model was considered to be elaborate, relevant, creative and well structured. It was considered an important contribution to the field of music therapy, viewed as distinctive in its addressing of voicework with the studied population and in its potential to treat vocal and speech disorders related to emotional issues in children. It was found useful for purposes of treating children with fears and anxiety, vocal issues and in working with children through voicework in general. Though believed to be attuned to the client and his needs, participants' statements elucidated the necessity to further emphasize that the application of the model in therapy must be adjusted to the client's emotional, developmental and cognitive level as well as to his personal rate of progression in therapy.

The Therapist

Experience. The model was evaluated as suitable for facilitation by music therapists, regardless of their experience in the field, with advantages noted for both experienced and beginning music therapists. Clinical supervision was considered necessary, especially for beginning music therapists implementing the model.

Qualities. Attributes of creativity, playfulness, flexibility and mostly uninhibited vocal expressiveness were found to be essential to the therapist implementing this model and will be added to those qualities previously suggested in Cycle 1.

Inhibiting factors. Varied aspects were found to negatively influence and restrict the therapist's use of her voice in therapy, thereby impairing the model's efficacy. It therefore appears necessary that the following key factors be addressed in order to enable therapists to effectively apply the vocal model in their work:

Lack of confidence in vocal skills. Though it was not believed necessary that the therapist be a professional singer or possess outstanding technical vocal abilities, it was agreed that the therapist should possess certain vocal abilities and control. These were viewed as obligatory in order to apply various vocal techniques and to incorporate the vocal improvisation included in the therapist's role, such as containment, grounding and imitation. A varied and expanded range of vocal possibilities may further allow the therapist to encourage and model many forms of expressive vocality to clients. Confidence in vocal skills was also thought necessary in order for the voice to become part of a therapist's easily accessible toolbox.

Lack of acceptance of own voice. The therapist's level of comfort with her own voice, with incorporating it in therapy and having it heard by her clients, was thought to be far more significant for implementing this model than her actual vocal abilities. Yet many therapists interviewed voiced varied insecurities regarding their voice and its use in therapy. The therapist's acceptance of her own voice (and of the client's voice by extension) and having a

healthy relationship with her voice were said to be key. This would seemingly require that the therapist accept her voice's limitations and imperfections and even be willing to use her voice improperly and make unconventional, "ugly" sounds, in order to exhibit and model vocal acceptance and uninhibited vocality to her clients. Being capable of vocal release and of using her voice freely and in an uninhibited, liberated manner requires that the therapist be uncritical of her voice and feel comfortable using it in therapy. Such vocal use may encourage clients' vocality, legitimize their use of vocality and model therapeutic uses of the voice throughout sessions.

Feeling uneasy with issues brought up by vocal use. Incorporating voice in therapy was found to have the potential to arouse in the therapist many inhibiting personal issues, including fear of exposure, avoidance of intimacy, religious concerns and negative associations. These may cause the therapist to avoid using her voice in therapy, to restrict her vocality and to transfer these tendencies to her client, thereby hampering the impact of the vocal model.

The therapist's anxiety regarding use of voice. The topic of the therapists' anxiety in regards to vocal use in therapy was frequently raised both directly and indirectly throughout interviews. Anxiety possesses the potential to be mutually infectious and as such may transfer from the client to the therapist and vice versa. Therefore, the apprehension exuded by the fearful or anxious child may affect the therapist's voice and its use the same way it affects that of the client, causing restriction and a tendency towards avoidance of voicework in therapy. Likewise, the therapist's subconscious fears, concerns and general stance towards voicework may be mirrored in the client's response and attitude towards the use of vocality in therapy. The therapist's varied insecurities regarding her voice or use of it in the therapy may similarly transfer to the client. Hence, it appears imperative that the therapist applying this model develop the ability and awareness to identify anxiety in both the client and in herself and to

avoid over-identifying with the child's anxiety. She should rather set inner boundaries and remain grounded when confronted by the client's anxiety in order for it to not affect her own vocality throughout sessions. She must as well consider her inner stance towards her voice and its application in the setting of therapy and attend to all related anxieties and insecurities.

It is thereby concluded that is necessary to address these factors that were thought to inhibit the therapist's use of vocality in her therapies in order to enable therapists to effectively apply the vocal model in their work. This may be achieved by setting a prerequisite to learning this model that would include undergoing a process of liberating the voice from inhibitions, expanding its expressive possibilities and developing its potential. This may be accomplished through participation in a group vocal improvisation course or in vocal workshops geared toward these goals. These measures may increase the therapist's confidence in her vocal abilities and aid her in developing a healthy relationship with her voice, leading her to feel more comfortable and uninhibited in regards to voicework in general. In cases of therapists dealing with substantial or deep-rooted vocal inhibitions and insecurities stemming from personal circumstances, undergoing an individual voice therapy process would be highly recommended. Therapist qualities and vocal abilities viewed as central to applying this model may be further developed through any training program instructing on this model. Such a program would include the addressing of issues relating to the therapist's anxiety, raising awareness to prevent this matter from negatively impacting vocal work with this population.

Application

Forms of application. Different possibilities suggested by participants regarding the model's employment in therapy will be noted. These include:

1. Full application: Systematic voicework incorporating either the entire model or appropriate phases from it to form a complete voicework process.

2. Partial application: Certain voicework phases or stages may be interwoven into another or perhaps pre-existing process as needed or deemed appropriate. This may enrich work already being done by the therapist, lending more depth to it or expanding it. This option makes it unnecessary to use the vocal model throughout the entire therapy process.
3. Occasional application: Certain ideas, tools, concepts or techniques may be borrowed from the model as needed and spontaneously incorporated in all therapies when deemed appropriate. This option makes aspects of the model accessible to many therapists, even those in different disciplines, and contributes to expanding the therapist's toolbox.

Incorporation in therapy. The main factors found to hinder the use of this model by therapists were:

1. Not being aware of the potential benefits inherent in voicework with children
2. Lack of knowledge of how to implement it in specific therapies
3. Lack of confidence in applying the model

This model's development will hopefully raise and expand awareness of the potential benefits voicework may contribute to therapy processes and serve to educate therapists in applying it. Having a concrete model to refer to may provide a technical anchor to further instill the confidence necessary for therapists' to apply voicework in their sessions. A training course teaching this model would expand therapists' knowledge of the model's applications throughout different situations that may arise in therapy and with diverse clientele. It would additionally advance awareness of the child's vocality during sessions and of the potential impact of vocal play. Demonstrations and simulations incorporated into any training course would further familiarize therapists with this model's possibilities of application, offer reassurance and potentially increase the therapist's confidence.

It became apparent through this cycle, that as in any form of therapy, the manner in which it is implemented is crucial to the model's effectiveness. It is therefore not only a question of

what is done in therapy, but of how it is done. It is thereby concluded that it is imperative that training in this model include experiential simulations alongside auditory demonstrations of such voicework in addition to clinical supervision once the therapist begins implementing the model in their clinical work. Exposing the therapist to the model in a variety of ways may allow her to experience and put it into practice even during the training stage. This will aid towards the achievement of flow and spontaneity in facilitation and in the therapist's increased sense of confidence and ease when applying the model.

The Vocal Aspect

Some of the exact qualities that were believed to make the voice therapeutic and effective in therapy to begin with, such as its ability to expose or touch upon the anxious child's areas of difficulty or blockages, also raised concerns that the voice may be experienced as overly revealing and exposing by certain clients, particularly during the initial stage of a therapy process. Additionally, concerns arose that the vocal model may be experienced as unfamiliar to the child, giving rise to apprehension or resistance. The need thus arises to further clarify the importance of incorporating the model gradually and sensitivity in attunement to the child's needs, responses and rate of progress within the model and therapy process.

The aforementioned additionally emphasizes the importance of implementing the pre-vocal stage of the model and adapting it as required for the client being treated, thereby very gradually introducing vocal aspects of the model when necessary. The pre-vocal phase of the model may therefore be extended to include more movement, work on boundaries and additional relaxation techniques beyond those suggested in Cycle 1, as participants viewed these components as especially significant in work with anxious children. This initial phase may serve as a prerequisite or bridge to introduce vocality into the therapy and to advance to further phases requiring more, less structured and less familiar forms of vocality. Additionally, in this phase emphasis will be put on imitation as well as on structured participation not

necessarily requiring the child to contribute or convey much from himself. It may thereby form a more calming phase for the client to provide a platform for him to be more creative and forthcoming in more advanced phases of the therapy.

General Guidelines

It will be clarified that, similar to any other therapeutic model, it may not be appropriate to apply this model with every client or at every stage of therapy. The therapist must exercise their professional judgment as to which client, at what timing and in what way this model and its components should be applied in therapy. It must then be applied sensitively with adjustments made for the particular client being treated: his personality, specific needs, emotional stage, cognitive level, personal progress rate and his relationship or dynamics with the therapist. These understandings and subsequent clinical adjustments should serve to combat possibilities of resistance and other undesirable reactions from clients.

Further Research

Several topics arose through this cycle that may be investigated in future research. These include the possibility of incorporating aspects of the model or adjusting it to treat additional age groups (youth or adults), other populations (such as non-verbal children) or different disorders among children. Additionally, the suitability for therapists from additional disciplines to implement this voicework model either fully or partially under specific conditions as suggested by participants may be further investigated. Participants interviewed in this cycle were experienced music therapists accustomed to using their voice and facilitating therapy in a certain way. It may be that addressing the issue of voicework early on in the training of music therapists, such as in those at the beginning stages of their professional studies, may yield a new generation of music therapists that feel far more comfortable incorporating vocality and encouraging it in their clients in their work. This is a topic that may as well warrant further research.

Further Developing the VocaPlay Model

The main drawbacks inherent in the video presentation used to relay the model to participants was that it did not demonstrate the integration of additional modalities inherent in the model such as movement and visual art and did not permit participants to personally experience application of the model's techniques to further clarify its use and to evaluate its suitability, possibilities and transferability to other therapists. These options were therefore made available in Cycle 3 of this study. In the following cycle, the vocal model was presented to participants through a six academic hour long experiential live workshop. Participants included beginning music therapists- students in their second year at the Music Therapy Training Program at Bar-Ilan University in Israel. This cycle made possible the contribution of the perspectives of this additional population of participants, which further included both male and female students with diverse vocal backgrounds. The inclusion of students as contributors to this cycle furthered the inquiry by examining the applicability of this model by music therapists at the beginning stages of their training, which had not yet developed a set way of working with clients.

In this cycle, the initial model developed in Cycle 1 was integrated with the expansions, modifications and concepts that evolved through Cycle 2. The main research question in Cycle 3 was: How is the integrated model experienced, accepted, and perceived by beginning music therapists? Questionnaires were initially sent to participants to learn of their vocal experiences, stances and backgrounds. The vocal workshop included a focus group, promoting the inquiry by advancing dynamic group discussion of questions, participant experiences and issues arising from the workshop. Additional queries explored with members of the focus group formed in Cycle 3 pertained to: The model's comprehensiveness when applied through simulations, ideas to further develop or modify the integrated model, and possibilities to improve its applicability for beginning music therapists. This cycle additionally allowed me to gain fresh perspectives

that would either solidify or challenge previous findings. It further allocated time for a more elaborate explanation and demonstration of the model, thereby allowing for an increasingly in-depth investigation, particularly of the model's various phases. Active participation and experiencing of varied techniques through simulations was thought to provide participants with additional insights and unique perceptions in relation to the model. All group discussions were audio-recorded and subsequently transcribed.

CYCLE 3

Method

In Cycle 3, the initial model developed in Cycle 1 was integrated with the concepts and understandings that evolved through Cycle 2. The work established in the previous cycles was further expanded upon by conducting a focus group comprised of music therapy students, based on an experiential workshop summarizing the model thus far developed through Cycle 1 and Cycle 2.

Participants

Participants were selected to participate in this cycle through homogeneous sampling (Patton, 1990). They included nine music therapy students in their second year of Master's Degree studies in the Music Therapy Program at Bar-Ilan University, Israel. These students included seven females and two males. They all had academic backgrounds in music studies and though they had varying degrees of vocal training, all had backgrounds that included performing in choirs/vocal groups and/or some extent of voice development lessons. Two even defined themselves as "singers". However, not all incorporated their voice in the music therapy treatments they administered in their field work and most of those that did, reported only doing so to a "small degree". Additionally, the students' stated degree of comfort with incorporating their voice in the therapies they administered varied as well, with some declaring in initial questionnaires that they did not feel comfortable or confident using their voice in their therapies, while others did. As a group, these participants had worked and were still working with assorted populations through their field work in music therapy, which included children, youth and adults with emotional, behavioral, psychiatric, developmental and neurological difficulties or disorders.

Tools

Data was collected through questionnaires (Appendix I), my observation notes, and through a focus group conducted throughout a workshop based on the vocal model studied. Morgan (1996) broadly defines focus groups as "…a research technique that collects data through group interaction on a topic determined by the researcher" (p. 130). In focus groups, discussions are facilitated by the researcher in an interactive group setting where participants may openly express their viewpoints and attitudes towards the subject researched. The "group effect" generated through the collective discussion and interaction may allow unique access to ideas, data and insights (Lindlof & Taylor, 2002, p. 182). A focus group was conducted in Hebrew and lead by me together with an additional group moderator from the music therapy field. Within the focus group, a short phase-specific discussion was generally held following the presentations and experiential simulations of every two phases of the vocal model, and a longer concluding discussion was conducted at the end of the workshop. Shorter discussions centered on the participants' thoughts and experiences regarding the model's phases in an attempt to improve its applicability for music therapists. The inquiry varied according to the evolving dynamics of the group discussions, though it typically consisted of four basic questions (Appendix J), including: What was your experience during the simulation? What would assist you in feeling more comfortable with the simulation? What would assist you in applying this phase? The concluding discussion touched upon more general aspects of the model (Appendix K) and included questions such as: What were your impressions of the voicework model? Would you feel comfortable implementing the voicework model in your work? Do you think the model would be suitable for children with emotional difficulties or additional populations?

Procedure

Participants were initially sent a questionnaire to fill out through Google Forms regarding their professional and vocal backgrounds as well as their use of vocality in the therapies they administered and degree of comfort they felt in using their voices in therapy. Following the signing of an informed consent form (Appendix H), they participated in a six hour workshop during which the voicework model thus far developed and revised through the previous cycles was presented, demonstrated and experienced by participants through simulations of interventions representative of each phase. These simulations took place following the presentation of every phase or two and were conducted in pairs, trios or as a group as the circumstances and allocated time allowed. I simultaneously observed and annotated by them. Subsequently, participants were given the opportunity to ask questions and discussions relating to the phase/s presented and experienced were conducted by the group moderators. A longer summarizing discussion was held at the workshop's end following the presentation of the entire model. All discussions throughout the focus group were audio recorded and subsequently transcribed (available upon request).

The workshop's structure is illustrated in Figure 4 (see below):

Figure 4

Cycle 3: VocaPlay Workshop Structure

Analysis Method

Filled-out questionnaires, observation notes and transcriptions of the audio recordings from the group discussions were analyzed using IPA (previously defined in Cycle 2). The analysis included the following stages: Transcriptions were read numerous times in order to familiarize myself with the material and then notes were written in the margins pertaining to my understanding of the arising material. As in the analysis of the previous cycle, a phenomenological perspective and interpretative perspective was noted alongside the participants' contributions. The unique circumstances surrounding each participant's voiced opinion and conduct during simulations was taken into account, including their background, personal experience and reported degree of comfort with their voice. I then combined the notes of all discussions pertaining to each topic into a list of rough categories. Subsequently, I searched for distinguishing features as well as commonalities in the experiences and thoughts mentioned under each category, or meaningful relevant segments of data. I then labeled the meaning units and group similar categories under one label that I felt described the entire group. Significant themes that emerged were used to attempt to draw further conclusions regarding aspects of the voicework model that evolved through Cycle 1 and Cycle 2.

The information emerging from this cycle served to advance the inquiry by considering the fresh perspectives of beginning music therapists currently learning the profession, who had not yet formed a set approach to their therapeutic work with clients. This cycle additionally allowed me to build upon the foundation of the presentation media formed in Cycle 2 and to evolve the presentation to incorporate a more interactive media, which included personally presenting the model, instructing on its application and responding to arising queries. Furthermore, advancing from theory to practice, this cycle introduced the aspect of participants personally experiencing the model, making available information pertaining to the participants' experience and applicability of the integrated model. Finally, this cycle allowed the further

attunement, modification and expansion of the model developed thus far, considering the additional observations and insights raised by this relevant group of contributors.

Ethical Issues

As aforementioned, the entire study (including this cycle) was approved by the ethical committee of the Music Department at Bar-Ilan University (Appendix B).

Client confidentiality was observed at all times throughout this cycle. No identifying personal client information was revealed in the model's presentation and consent from clients' caregivers was obtained to include audio demonstrations and art work in the presentation. Additionally, participants were required to sign an informed consent form which included clauses prohibiting the audio or visual recording of the presentation and its contents and agreeing to keep the identities of the additional contributors and any information discussed during the focus group confidential, in order to protect the other members. Participants were guided to conceal the identity of their own clients throughout the focus group, referring to them by pseudonyms and obscuring any identifying personal information. The identities of contributors to this cycle were concealed. They were referred to by pseudonyms throughout this work and will remain strictly confidential.

Trustworthiness

Precautions were taken to ensure the integrity of this research:

1. Triangulation, involving the use of different data collection strategies throughout the research, was used to this end. The methods of questionnaires, observations and focus group employed in this cycle are prominent in much qualitative research and the latter adds to the strategies used in the previous cycles. As previously proposed, this use of different methods within the study may compensate for their individual limitations and exploit their respective benefits.

2. In congruence with the study's methodology of AR, this cycle allows further scrutiny of my viewpoints, assumptions, conclusions, and course of action by others in the field. It makes possible the ongoing modification and testing of the studied model with the active assistance and participation of co-researchers, in response to their perspectives, experiences, and observations. This course of action contributes to the study's subjectivity.
3. In regards to transferability, detailed descriptions of all occurrences and background data will be provided within the study to establish its context and the study's limitations will be made clear, in order to allow comparisons to be made to this study's findings in future research done on this topic.

Findings

Four main themes and twelve sub-themes were identified through interpretative phenomenological analysis of the materials. Main themes include: Model presentation, participant experiencing of simulations, impressions of the integrated model, and views regarding the therapist best suited to incorporate the model.

1. Presentation

The frontal presentation of the model studied allowed me to immediately clarify participants' queries, thereby contributing to their accurate perception and deeper understanding of the model. The format used in this cycle additionally allowed discussion related to the model's phases immediately after they were presented and therefore fresh in the minds of contributors.

Participants felt they benefitted from the workshop presentation format used to convey the model in this cycle and reported finding it comprehensive, instructive, practical and enjoyable: "It opened something very childlike and fun in me and also enabled me in a very protected and safe way to sound very strange voices that I don't give voice to in my everyday

life." –A., "The way you presented it, simplifying the voice, the power the voice possesses, the identity with all the images and games that you did- I liked it very much. Your approach reveals the person's voice." –Y.

An additional advantage to this form of presentation was that many participants reported that they gained tools and ideas they felt they could already apply in their field work even through the short workshop and the experiences it allowed:

> "It's possible to already now take small elements here and there at the level of the rationale. And if something suddenly arises in our therapy work it's actually possible to use that knowledge we attained, the rationale itself of what the goal is, and to apply it." –A.

2. Simulations

2a. Researcher's observations. The simulations that the students participated in throughout the workshop appeared to bring out many creative responses, humor, playfulness and varied vocality in participants. Participants that spontaneously began vocalizing at the beginning of the simulations tended to form more playful interactions, sounded more diverse and expressive vocalizations and reported a more satisfying and releasing experience than those who initially hesitated and attempted to plan their vocal expressions and interactions. The latter group had more measured subdued vocal interactions, emitted more limited vocalizations and reported feeling less at ease than the former group.

Participants were able to apply the voicework techniques discussed and spontaneous variations on these techniques naturally occurred throughout the simulations. Those who felt more comfortable with their voice proceeded along the phases with far more ease, confidence and spontaneity than those who initially reported (in questionnaires) feeling less comfortable using their voice in their work. Those in the latter group expressed the need for more of a

process beyond a singular one-day workshop to feel more at ease in some simulations, especially with more exposing or complex forms of vocality.

Each pair or small group of participants tended to take the experience to a different place, emitting different voices and creating unique interactions. Specific unions among participants additionally appeared to affect their vocal release and level of comfort within the simulations, with both positive and negative interpersonal impacts occurring and influencing vocal interactions.

2b. Participants' general experiences. Participants shared their experiences of the simulations they participated in throughout the workshop during the focus group. Phases were typically viewed as logical and well measured, effective in aiding the anxious child to gradually adjust to and incorporate vocality in the therapy. They were generally experienced as fun and enjoyable and brought out the child in many of these adult participants: "It opened something very childlike and very fun in me and actually enabled in a very protected and safe way to emit very unordinary voices which I don't do in everyday life." –A.

Movement was a component in most of the simulations that was consistently reported to aid the participants in reducing tension and in releasing vocality.

As a group that was accustomed to working together, most of the participants reported feeling comfortable in the beginning stage simulations. However, the more emotionally exposing phases were experienced as more difficult in the context of a one-day workshop which could not allow an actual therapeutic process to transpire. Time to undergo a gradual vocal process themselves, a one-on-one intimate situation and the building of therapist-client trust were mentioned as key elements thought to improve the level of comfort in those who felt less comfortable in simulations:

"…here (in the workshop) it's very quick and it requires a process." –F.

> "I think that ultimately it's one of those things that I avoid and the moment I do them I understand the liberation and fun in them. But there's a blockage and I believe that it's something that requires time and also some trust with the therapist and person with you in that situation which is intimate and exposing." –O.
>
> "The trust between the therapist and the patient will allow the patient more freedom in my opinion." –F.

It was also suggested that adults have a tendency to over think things and that children would most likely be even more at ease and freer in their vocal expressiveness in the interventions practiced:

> "I think it's even simpler for children than for us…. children feel very comfortable to just do, to flow with motions, with the voice. It comes naturally. For instance, I felt I needed to think about every movement and I told myself 'try to think for a moment like a child'. Simply, whatever comes out with the motions and with the voice." –O.

While structure was thought desirable in initial phases when the client may yet be timid and uncertain, it was found to be less necessary and even possibly hindering in more advanced phases of the model. In these later phases, it was deemed more appropriate to give the client more leeway to fully explore his individual voice.

The suggestion of applying certain techniques to group work arose from the group of three participants that was formed (due to the odd number of participants). This small group had an especially positive experience in the simulations. They claimed benefits to this group interaction that included exposure to diverse and inspiring vocal reactions as a result of the collective experience.

2c. Participants' experience of specific phases. After being presented the concept of a phase or two at a time from the model, listening to relevant demonstrations and having the opportunity to personally experience techniques from them, participants offered their views

and shared their experiences during the subsequent focus group. At times, simulations combined techniques representative of two phases at once. This pairing will be reflected in this section's headings.

Pre-vocal and Vocal Togetherness. The Pre-Vocal phase was thought to be suited to promoting the goal of releasing vocality and in helping the client feel comfortable using their voice, thereby bridging towards the use of voice in therapy: "It was as if this really was the connecting phase that made me feel afterwards comfortable to sing or improvise something." –O., "There are sparks of vocal work from this seemingly very primary place. It introduced something new to me and I think it very much opened me, really enabled me to release." – R.

The combination of the elements of breath and movement in this phase were found to be very potent, both aiding the release of tension, with the breath additionally helping to focus the voice's sound: "I also really think that the breaths really help to focus how you want the sound to come out."- T.

These initial simulations were also felt to promote communication and connection within the therapy session: "It's a great way to connect and enable getting to know one another." –Y.

The kazoo was considered by many a non-threatening way to promote playfulness and release: "It's really something that very much opened me." –S., "Through the instrument (kazoo) it's not threatening, it's enabling and it was good. I really felt that at some stage my entire body responded to it, answered all these sounds and I felt that something very childlike and fun opened in me and we laughed a lot. It's enabling." –A.

Use of the kazoo allowed an experience of more vocal control and empowerment for a student who felt uncomfortable with his vocal abilities:

"Personally, as someone who doesn't feel so comfortable with his vocal abilities, even though I'm in music therapy, I actually felt I preferred the kazoo over the voice.

> Meaning, the kazoo suddenly had more volume. When I left it and began to sing I wanted to bring back the kazoo because I suddenly felt I had better control over it." –T.

While empowering to some, this change in vocal effort to exert sound from the kazoo proved to be limiting to others, who felt at some point that the kazoo was holding them back from their full expressive potential: "Suddenly, as much as I was enthused by it in the beginning I wanted to leave it and just sound my voice, which is amazing." –S.

The kazoo was further found to encourage vocality through its humoristic aspect [There's something fun about the kazoo that adds some comical dimension that kids can perhaps really really enjoy. It's a humoristic shade for a child that creates singing through the kazoo. It can encourage him to vocalize more." –F.], vocal cord involvement ["It requires that we really speak and sound our voice." –R.] and masking qualities. These were believed to help with the exposure some felt with actual vocal use: "There is work here which is already actually vocal with some masking that really helps…. the moment the kazoo is gone there is some sense of great exposure." –R.

Transitions from kazoo to voice in the simulation were natural for some and more difficult for others, with some students preferring to remain with the kazoo for longer and other feeling they were ready rather quickly to set it aside and sound their singing voice without it. The importance of structured gradualism was raised and ideas of different ways to create the transition from kazoo to vocality were suggested:

> "Even sentence-sentence or having the kazoo enter in some repetitive element that repeats itself at the end of each sentence." –R.
>
> "Maybe word-word? Also, maybe some playfulness in the transition between playing the kazoo and singing." –F.

> "I think it's also possible to take a certain song, it can also be a short song, and we can sing it together (with the kazoo) and on certain words take the kazoo out…. and then to begin slowly reducing (the kazoo's part) and then afterwards pass the role solely to him…" –Y.

Once again, guidelines regarding adjusting each intervention to the specific client being treated arose with the issue of transition as well as with inquiries regarding how much initiative may be expected from the patient during these initial phases: "I think it really depends who's sitting across from us…what child and what stage of readiness he's in." –A.

Vocal Liberation and Vocal Structuring. Visual aids, the accessory of a ball, movement, playfulness and therapist modeling were all felt to aid in and to encourage vocal variations in pitch and vocal liberation, even more so when used together and combined as in the simulations. Participants reacted with varied and spontaneous vocality to these simulations.

When drumming was introduced during a simulation, it prompted more dynamically powerful vocalizations and clearer articulations from the participants.

The rhythmic component of the Vocal Structuring simulation was experienced as particularly powerful and influential: "I purposely tried to resist the rhythm during the gibberish (in the simulation) and I couldn't. So there is a lot to that." –B.

Vocal Expression. The accessory of the scarf was said to aid in the emotional expression inherent in this phase and in signifying the passing of turns by throwing it to one another according to the timing participants felt necessary. The use of visual images additionally helped to achieve the goal of this phase by connecting participants to emotions, especially at times when this was more difficult for them (-O).

While some pairs and a group reported that the simulation flowed effortlessly for them and described feeling connected and relating to the emotions expressed, other pairs stated that they found it rather difficult. Hindering factors mentioned in this simulation were:

1. The choosing of stronger emotions (anger/excitement or frustration/complaining) over less emotionally taxing emotions.
2. The choice of specific emotions rather than situations or themes (such as end of semester exams, children), as this tended to limit their range of their expression: "I think the essential difference between choosing a theme and choosing an emotion is that when you choose a theme it gives a range of emotions….it gives an opportunity to express something more dynamic" –F.
3. Over thinking and trying to plan ahead of time how the vocal expression should sound or how one should feel: "I began thinking 'how do I now make music or sounds or expressions or some gestures that bring something here' and then it really disconnected me from the emotion. It made me only use my brain…. thinking how it is supposed to sound" (–T.), "I think I tried to know how it feels when you're calm, even though it was my emotion (that I chose). I tried to think how I'm supposed to feel" (–O).

Vocal Empowerment and Vocal Confrontation. The aspect of vocal empowerment within the simulation was thought by participants to be releasing and effective for children, with the integrative aspects of movement and visual concreteness contributing greatly towards it: "There is something very liberating in it and if I were a child, I would find it very inviting. To throw and also to imitate all sorts of voices- It's very inviting for children. Even for me it was very releasing…" –A.

Most participants seemed fairly comfortable experimenting with their vocal dynamics through the simulation to at least some degree.

The aspect of confrontation of fears however was met with mixed levels of comfort from the group. Some participants expressed a need for more time to undergo a process to feel fully comfortable in the simulation and stressed the importance of going through all prior phases in the model to prepare for this one. Conversely, other participants had no issue with

fully and freely participating in it: "I actually felt very free to point at the fear, to deal with it….I felt comfortable throwing and sounding a voice in which I express what I have, which is a good way to release." –Y.

Playfulness, movement and vocality were components that were found to particularly aid during this simulation: "When it's play along with voice it's releasing. You feel you're not alone, like there are other things with you in this situation." –Y.

Confronting the fear was felt to be empowering and releasing and identifying the fear and giving it words was viewed as important. As fear can be paralyzing and felt more than it can sometimes be explained according to participants, creating a dialogue with the fear was thought to hold the potential to release the patient from this paralysis and help him find his voice.

> "I think that's actually its strength- to verbalize what's frightening me because fear is paralyzing. We're in something that has no words. We feel it physically and just saying something to that fear seems to me to correlate to something that is in the sub-consciousness…it helps to release it, to conceptualize it….to find your voice within this chaos." –B.

This phase was therefore also considered useful as it was thought to make the fear more concrete to the child and therefore something that may be dealt with: "(The child) sees the fear, takes the ball, throws it at it and says something to it. I do think it is effective." –Z.

Vocal Image. The participants related easily and quickly as a group to the images shown to prompt additional vocal characteristics. These subsequently led them focus on vocal image (*e.g.*, the brave/childish/tough/unpleasant/feminine/frightening voice). Vocal ingredients immediately and collectively took on flexibility and extreme variations. An atmosphere of playfulness and laughter ensued.

> "…through the simulation I discovered that I also have all the characters within me. I'm sure I knew that but it raised it to my consciousness in my quick response to the images. Not just mine but everybody's. Suddenly we all began to sing (according to the images) without any planning among us…." –A.

Participants mentioned finding the incorporation of images borrowed from the child's world in the simulation especially appropriate, as it was felt to make it especially relatable to children.

Vocal Processing. The final phase was believed to be an essential part of the model. It was thought to bring together experiences from throughout the process and to assign meaning to them, while promoting the client's therapeutic insight: "I think that at this stage insight is truly achieved, because the experience from each phase is actually experience plus experience plus experience and you get the entirety of it all at the end. That's why it's integral to have this phase at the end." –A.

2d. Significance of accessories. The simulations in this cycle brought forth the topic of the significance of the accessories and visual aids incorporated within interventions throughout the model: "I do feel that there is something in the accessory, like with the ball or graph, kazoo, anything that is a mediator as well as in your choice of accessories which are very simple but do a lot of work." –R.

Participants suggested that each accessory incorporated in the simulations encouraged different vocality and interaction or dialogue between therapist and client as well as encouraging the expression of different emotions. Examples given were:

- Visual aids: The use of images aided in connecting participants to emotion, while the drawing of pictures or use of vocal graphs was felt to add an important visual dimension and aspect of concreteness to the therapeutic work done.

- Ball: This was thought to promote a more playful interaction between the therapist and client, more spontaneous vocality and the expression of more direct and stronger emotions, such as anger.
- Soap bubbles: These were suggested to be especially appropriate for the initial, pre-vocal phase. It was thought to promote breathwork and to be useful in initially prompting vocality, alongside playful therapist-client interaction.
- Scarf: This was viewed as elastic and flexible, providing the possibility of passing it to another in an array of manners. These characteristics also allowed it to take on different shapes of objects in some interactions, such as a pillow, a rag getting water squeezed out of it or a parachute:

    > "There is something so elastic and flexible, the shape can change and the passing of it from one to another can be done by throwing it and can also be in a far gentler manner. There's the possibility of throwing it high in the air and watching where it falls." –R.

  The scarf was viewed as "having breath", light and airy. It was thought to encourage the expression of emotions, especially emotions considered more "delicate". It additionally gave rise to much creativity and spontaneity among the participants while expressing what they had decided on through it and created a flow in general:

    > "The scarf really brought out some sort of creativity from us… we found that the scarf can express many emotions. We could have continued with it much longer (in the simulation)." –S.
    >
    > "Regarding the scarf- it's not like we put thought into it. I think it was simply spontaneous. It just brought this thing out of us… it really flowed for us. It simply brought out a wide range of emotions and it also felt very connected." –B.

This accessory was also found by participants to enable group work by further clarifying the issue of turn taking: "The moment the scarf entered the picture it made it possible to also work in a group." -A.

A suggestion stemmed from this discussion to allow clients to choose from a variety of objects when they choose an emotion to improvise on (a ball for ager, scarf for happiness…), similar to choosing a musical instrument before expressing oneself in the music therapy session.

3. The VocaPlay Model

3a. Impressions. The impressions of the model expressed by the participants were positive in nature. The model was viewed as useful ["It has good techniques and may really work well…" –Y.], expansive ["I see an extremely encompassing viewpoint…" –F.], effective ["Together with the additional incorporation of playful elements, it's simply a strong model." -O], and enjoyable.

The main constituents of the model mentioned to be advantageous by these contributors were:

- Structure and order: The clear therapeutic rationale and comprehensiveness inherent in the model's structure added to the therapist's ease of applicability:

  "There is a very very clear structure here which creates order. If I wanted to work with this model as a therapist, it possesses something very inviting with the order it brings." –R.

  "It’s very process minded, very constructed, which is a good thing."-F

  "From my experience so far in my field work I have realized it is immensely difficult for me to function with a child or patient when I don't have a therapeutic rationale in the back of my mind.… The model provides me with that: The

processes, the stages, what the objectives are and what exactly the therapist's role is at every stage." –A.

- Flexibility and fluidity: These were found both within the phases and in the model's structure: "There is something in these stages that you feel the flexible conception in. I can see how they lead from one to another, but there is also much emphasis that they can be extended as long as they need to be…." –R., “You can always move back and forth." –A.
- Gradualism: This was established among and within the model's phases and stages, in the transitions between them and in the therapist-client interactions:

  "I think it's a very strong model that also relates to the stages a person goes through and emphasizes his preparedness in the transition from one stage to the next." –O.

  "One thing is built on the other and leads to the other…. you have that in many things: the interventions, the use of accessories in a gradual way, the play which is between one and the other with mutuality. That's something that feels very right." –F.
- Playfulness: The component of playfulness in the model was believed to aid in the release of vocality and of tension and anxiety in general, contribute to the child's cooperation in therapeutic interventions, promote the formation and building of the therapist-client relationship, encourage creativity in the client and advance enjoyment in therapy.

  "I think playfulness not only helps in release and in reaching cooperativeness in doing one or another activity, it also encourages creativity and it's also fun." –O.

"Playfulness is very central here, it really lowers the anxiety. I can imagine myself as a child and what would happen if I now didn't have to focus on my vocal production but on something else as my focus right now. It really very much lowers the tension." –B.

"Playfulness is definitely very important." –Y.

- Supportive techniques:

  "There is much support in this model that may enable and help the child or any person." –O.

- Integration of additional mediums:

  "There really is a sense of enablement and support from additional mediums. We had art and drawing, play and accessories and other objects and tools, wind instruments and things which are not insignificant…. The focus is on the voice and you're not afraid to integrate additional mediums and I think that's excellent. It works." –R.

3b. Relevance. The model's foundation of vocality was viewed as possessing the advantages of incorporating a medium that is universal, emotionally expressive, easily accessible and a natural, mutual component of both the client and the therapist and therefore not foreign to either of them:

"The voice is something which is not just a means to an end. It is "the" thing. That's how I feel. It is something which is accessible to everyone, that everyone uses, that everyone experiences or understands the power of emotions through it." -B.

"It is a very essential model in any therapy in my opinion…I can immediately internalize it since I didn't do anything that is outside of me (in the simulations) … I found myself in it." –A.

3c. Applicability. All participants said they would feel able, willing and comfortable applying the model presented given appropriate training and for some, given more time to undergo a vocal process themselves: "I myself am a voice development teacher and many times in therapies I thought how to insert vocality. Here I was just given so many ideas and things that can help… In the future I can use it (the model), and looking back on the past I can learn from it." –Z.

Participants gave examples throughout the workshop of ways they thought they may even currently apply some of the model's vocal techniques or interventions in their own music therapy work: "I really took the 'Vocal Liberation' to my field work (in my thoughts) where I have a patient that says only 'me' and I try to get out of here other sounds all the time and imitate her. This seems to me something that I can try to take and see if it works." –S.

Many began thinking of variations on the vocal interventions mentioned throughout the workshop that they could adapt to suit the model to their clients' specific needs:

> "I would use the kazoo in some game… some game that we would speak through the kazoo in the game. Like right now we'll play a children's game but we'll always use the kazoo to encourage a conversation and I also think it would really cause the child to laugh.…" –S.
>
> "I think maybe like the ball, something that can also help with the vocal expression of emotion is a punching bag, and make the vocal sounds of my fists hitting the bag. It can be something more like a sustained "mmmmm"!" –F.
>
> "At this stage, if let's say you've reached a situation where he (the child) is already imitating you for a while, so you can say 'okay now I'll imitate you'." –O.
>
> "How about let's say the patient himself draws and as he does so he uses the vocal play as in the phase of 'Vocal Liberation'?" –A.

"Let's say the child draws a flower- so the stem can be 'aoooo aoooo' like a vocal drawing." –S.

3d. Suitability to additional populations. All participants strongly believed that the model, or many components of it, could be useful and effective with children with additional emotional issues other than fears and anxieties: "I think it's possible to take elements from each phase and use them for treatments which aren't related to fears." –A., "I'm going over patients in my head and already have an idea of some that could very much benefit (from the model) and not specifically because of anxieties…. perhaps other emotional difficulties and I don't see any reason why it wouldn't be suitable." –R.

They additionally suggested that the model may be applied with many other populations and age groups, especially if appropriate adjustments were made for each phase: "It's so fun, no matter at what age to experience that place of playfulness and through it to advance to all sorts of places." –O., "There would need to be adjustments made since the approach to fears may be different…. but ultimately, the vocal work may contribute to other cases as well." -R. Among the populations specifically mentioned were:

- Non-verbal children or youth:

  "I'm currently working with teenagers on the (autistic) spectrum with intermediate functioning and lower. Not all are verbal and I think that all the vocal playfulness and artistic elements and such can also encourage speech, conversation, to even sound the voice. They are often silent and do not speak, so it's possible to use the different elements towards other goals." –A.

- Youth with social anxiety:

  "I work with teenagers with social anxiety…. I kept on thinking what I can take and where I can integrate it with them." –B.

- Children and youth with cognitive disorders:

"I work with teenagers with borderline IQ and very low cognitive levels, and consequently low emotional functioning. Sometimes with 13-14 year olds whose emotional level is like that of 6 year olds. It (the model) may also be very much applicable with such a population…" –F.

"I think it may also contribute to additional children. I'm thinking of a student I had with selective mutism along with retardation. I think it's perfect for her, and she's not at a normative level (cognitively). I think it's beyond children with emotional problems with normal development. It can be opened up to additional populations...." –S.

- Physical disabilities:

  "I'm thinking about the population of C.P. (cerebral palsy) …. there are also all sorts of interventions that may apply to them without requiring physical movement." –A.

- Adults with vocal issues:

  "There are also adults that have some difficulty with their voice and (ensuing) self-image." –S.

- Groups: These included diverse group situations that integrated voicework, such as therapy groups, singing groups, vocal ensembles and choirs with sensitive or even normative populations:

  "In general, I was thinking that it can be suitable to a larger group, not just therapist-client…. what we did in a group of three was even more interesting because of it and we applied a situation that everyone took in a different way with different feelings…"- B.

  "It can be interesting to see how perspectives of non-formal voicework can be formed through the model. I think there are tools we can take from the model

> that may also serve additional situations in which the voice is used. It can be another angle… the situation of a choir, a situation which is more social, groups which include vocal work. I work with a group of children which is sort of like the school choir. It's not defined as a therapy group, but still I feel that perhaps the approach which I use to introduce a song, deliver a song and create vocal interaction among them can be very influenced by this model." –R.
>
> "I have an integrated choir at a school: Regular children and special education. There are certain interventions that I saw that are very appropriate to try with the choir, whether it's improving a child's self-image or helping him or others stand out, or generally developing everyone's vocality. In short, I think it could serve very many goals." –S.

Participants expressed much interest in learning how to apply the model with varied populations they came across in their work and conveyed the opinion that every population may benefit from such therapeutic voicework: "There is much work on the voice here which every population can work on and do emotional work through." –F.

4. The Therapist

4a. Vocal background. Participants pointed out that the voice need not necessarily be the therapist's main instrument in order to apply the model. This was viewed as an advantage by some as it was thought to make the model more accessible for music therapists for whom the voice may not be their main instrument: "I actually didn't get the impression that the voice necessarily needs to be a main instrument (for the therapist) in order to incorporate this model. That's also an advantage." –Y.

Being a singer or even having prior vocal training was not viewed as particularly necessary by the participants and even those with little or no vocal backgrounds testified they felt they could apply the model in their work: "I have no background of anything related to

vocality and I felt I could also use this (the model) a lot in my work with my patients in field work and I'm not concerned about doing so because it's something that could work well." –S.

4b. Vocal abilities. Vocal elasticity and freedom were the main vocal components believed necessary to properly model different vocal possibilities for clients: "…Many times they (the patients) will do exactly as we do, or take it very much as an example, so there is a need for us as therapists to be able to (vocally) diversify…." –R.

The matter of the therapist's degree of comfort with using her voice in therapy and her relationship with her voice were viewed as the most significant aspects in deciding a therapist's readiness for applying the model:

> "I think that there is a basic need for the therapist to feel comfortable and he must feel connected to his voice in one way or another and be familiar with it…but there is no need to be trained as a singer." –R.
>
> "The issue of release and connection (to the voice) is important. There is less need for a background of singing because it comes more from an emotional place and a connection to myself and not from a place of proper and good vocal production." –B.

4c. Training. It was agreed on by the participants that any training in VocaPlay Therapy should include personally experiencing it: "(I would want) practical training, really experiential. One stage after the other, to delve into the model but mostly to experience it, which would make the connection (between theory and practice) possible." –A.

All participants felt it would aid them to undergo such a vocal therapy process themselves and to touch upon their own fears and anxieties as preparation for incorporating the voicework model: "…to experience ourselves some of the interventions and undergo some form of prior process before bringing it to patients." –R., "It would really help me to undergo such a therapy myself. To meet with my fears and see how it is by me and from there to proceed." –A.

3d. Professional experience. Participants did not think that applying the model required a specific amount of experience in the music therapy field. Furthermore, they maintained that they saw no reason why the model couldn't or shouldn't be taught already in the initial stages of a music therapist's professional training: "I don't think there is any reason to wait for us to be experienced in the field (of music therapy) or be a certain amount of years in the field for us to be able to learn (the model)." –R.

The possibility of being able to learn the model as music therapy students was viewed by the participants as something that could benefit them in several ways. They expressed the notion that it may allow them to incorporate the powerful tool of vocality in their therapies as well as validate the use of their voice in therapy at this early, crucial stage of their training. They additionally felt that learning the model could contribute to their current field work and supply them with additional tools to incorporate in their therapies:

> "The voice is an extremely integral thing, a basic part of us. It (the model) gives us as students and as young people in the field the legitimacy and also the tools to already incorporate it…. it's also possible to borrow from it not only the vocal process, but also small things and to apply them." -F.
>
> "I think it's important, essential. I think it gives a great many tools. Also, as a student I have field work hours. It is something that can contribute. Similar to material we learned in "models in music therapy" (an academic course), I think this is also something that is necessary to study… I think it is important to have the opportunity to learn it." –Z.

Students maintained that even the short workshop presenting the VocaPlay model had helped them understand the importance and role of the voice in therapy, perhaps influencing their increased use of it in their therapies: "I think that what I took today (from the workshop) was increased awareness to the subject of vocality. It's a topic no less important than musical

improvisation or conversation. Suddenly the issue of vocality really reverberates with me…." –Y.

Discussion

Conclusions from the previous cycle alongside its contributors' suggestions were implemented during the model's presentation in Cycle 3. Findings from this cycle assisted in drawing conclusions in regard to queries raised in Cycle 2, while further contributing to the development and modification of the model studied.

Presentation

The six-hour workshop conveying and demonstrating the model offered participants the possibility to personally experience key aspects of the model's phases through simulations. The frontal presentation of the model studied allowed me to immediately clarify participants' queries, thereby contributing to their accurate perception and deeper understanding of the model. The format used in this cycle additionally allowed discussion related to the model's phases immediately after they were presented and therefore fresh in the minds of contributors. Furthermore, the workshop format of this cycle allowed multifaceted aspects of the model regarding integration of additional mediums more of a platform. These included visual and concrete demonstrations that included client's drawings and visual representation of the auditory dynamics inherent in the audio recordings of client's voices. Simulations further included visual aids and additional expressive modalities such as movement and the incorporation of accessories in therapeutic interventions.

This concise workshop format was found to be an effectual and helpful way to convey the model's concept and objective and to review its applications. Participants relayed benefitting from the workshop presentation format and reported finding it comprehensive, instructive, practical and enjoyable. Moreover, many participants demonstrated the ability to grasp the underlying concept and to theoretically apply it to their therapy work. They further

reported gaining practical tools and ideas they planned to implement. This format was thereby found to be a useful tool in this study's objectives of accurately conveying the model's concept, options and goals, while allowing personal experiencing of it that may contribute to its applicability for the music therapist. This concentrated format contributed to making the acquaintance with the model convenient and practical. However, results from this cycle revealed that training therapists in this model would require further, in-depth knowledge of the model and of its applications. It was additionally found to be integral that therapists themselves be given time to undergo a process of gradually exploring the various forms of vocality and vocal interactions central to this approach. This may contribute to them gaining experience and thus confidence in applying them. Participants' experiences of simulations further found that therapists who did not initially feel comfortable incorporating their voices in therapy would require additional time to undergo a personal process of vocal release and of forming a positive relationship with their voice. Moreover, though some instruction on adjusting the model to meet the needs of individual cases was offered throughout the workshop, training therapists in this model would require more extensive and individually tailored supervision of therapists' work with clients. Such training of therapists in this model as described above was beyond the scope of this study, but may prove beneficial as a topic of future research.

Non-vocal Elements

The significance of the integration of non-vocal elements in different phases and for different interventions was brought to light through this experiential cycle. Anything supplementary to voicework was considered to be therapeutically significant. These findings accentuate the importance of applying thought and professional judgment when applying non-vocal elements to vocal interventions, as these may affect the vocality of both the therapist and the client as well as the interactions between them. These conclusions may further guide the therapist when deciding with which client and at what phase in the voicework model it may be

appropriate to incorporate these non-vocal elements, which include: Accessories, musical instruments, and additional expressive modalities.

Accessories. The simulations in this cycle brought forth the topic of the significance of the accessories and visual aids incorporated within interventions throughout the model. Among these were visual images and graphs, scarves, balls and balloons.

It was concluded that each accessory incorporated in the simulations held the potential to promote different vocality and interaction or dialogue between therapist and client as well as to encourage the expression of diverse emotions. It was thought to be beneficial to allow clients to choose from a variety of possible accessories when choosing an emotion to improvise on.

Musical instruments. Musical instruments incorporated within interventions were found to additionally influence the client's vocality and his interaction with the therapist. Musical instruments were considered especially relevant to the model's initial phases. The modified pre-vocal phase presented in this cycle focused on the transition between such instruments and the voice and was found both appropriate and effective when adjusted to the individual client.

Wind instruments. All wind instruments were considered useful in prompting an initial client-therapist interaction reminiscent of a verbal dialogue while promoting use of breath in therapy. The transition from wind instruments to voice was considered an aspect central to the model's application. In general, simple wind instruments that easily produce sounds through the focused use of a small to moderate amount of breath were found to be beneficial in initially prompting the mindful use of breath in therapy. Examples of such wind instruments include Brazilian whistles, plastic slide whistles, harmonicas and small reed horns and ocarinas. Wind instruments that required more breath to produce a meaningful sound promoted deeper breathing while inhaling as well as a lengthier exhalation (the very type of breathing considered

to advance calmness). These include the brass slide whistle, various trumpets and the ram's horn.

Kazoo. The kazoo in particular was found to be highly significant in prompting vocality as playing it requires vocal cord use. As such, when incorporated correctly it was found useful and effective in bridging between the client's use of wind instruments and his initial integration of vocality in therapy. The kazoo was additionally found to encourage vocality and ease clients' fear of vocal exposure through its non-threatening appearance, humoristic sound and vocal masking qualities. These aspects were also found to advance playfulness and release in the client-therapist interaction. Additionally, the kazoo may offer an experience of vocal empowerment and control for clients who lack confidence in their vocal abilities.

Drums. Most types of drums were found to beneficially influence clients' articulation and to mostly promote vocal empowerment and the vocal component of loudness in clients. The incorporation of drums in vocal interventions tended to lead to a bolder and playful vocal interaction between client and therapist as well as legitimize the vocalization of more powerful emotions (such as anger or frustration).

Microphone. The incorporation of a microphone in the sessions was thought to prompt vocality in general and spontaneous vocality in particular. It was additionally believed to promote variations in the client's vocal volume and to aid in vocal empowerment. Specifically, within the context of vocal interactions with the therapist, the microphone was found to be beneficial in indicating and encouraging turn taking (by passing it to one another), and in promoting verbal dialogue, vocal imitation, or continuity of vocal themes.

Additional modalities. The aspect of the integration of additional creative and expressive modalities such as movement, art, and drama were emphasized in Cycle 3 in the model's presentation and in simulations, following suggestions arising from Cycle 2. It was viewed to be appropriate and beneficial in this final cycle, as these modalities were found to

support and encourage vocality in their unique ways. These additional modalities were thereby believed to significantly contribute to the model.

Applicability

The integrated model was established as being generally transferable and applicable. It was concluded that it may be applied by other music therapists, including beginning music therapists with limited field work experience and from diverse vocal backgrounds. These findings were based on the following considerations:

Accessibility. Vocality was viewed as an easily accessible and universal medium which is naturally and mutually used by both the client and the therapist. The finding that the voice need not necessarily be the therapists' main instrument in order to apply this model was thought to additionally make it more accessible for music therapists for whom the voice may not be their main instrument. The model was further thought to incorporate common, easily obtainable accessories and mostly basic musical instruments and equipment commonly used by music therapists.

Adaptation. Participants were able to consider ways to adapt the model to suit their particular clients and their unique needs. This required the ability to fully comprehend each phase's concepts and goals and to use the flexible thinking required in the application of this model.

Testimony. Following this cycle's concise workshop alone, contributors reported feeling able and willing to currently apply the model's general concept and tools from it in their field work.

Comprehension. Contributors reported that the model's clearly structured approach and evident therapeutic rationale for each phase contributed to its comprehensiveness and thereby to their sense of being able to confidently apply it in their work.

Demonstration. Further evidence to the model's applicability was the participants' generally successful application of representative interventions throughout this cycle's simulations and their ability to create variations of interventions, alongside their ability to comprehend the rationale behind these.

Degree of comfort. Even those participants lacking in vocal confidence or experience expressed the notion that they would feel comfortable applying the model following training and undergoing their own personal vocal process.

The Therapist

This cycle further clarified aspects regarding the therapist that this model may relate to and the form of training that may be required for the music therapist to successfully apply the model in their work.

Vocal background. It was not considered obligatory that the voice be the therapist's main instrument in order to apply the studied model. Beyond this, little importance was placed in this cycle on even having a background of prior vocal training, as participants with little or no vocal backgrounds expressed confidence in their ability to apply the model regardless of vocal experience and proved able to do so throughout simulations.

Vocal abilities. It was considered necessary for the therapist to possess a flexible and unrestricted voice in order to properly model different vocal possibilities for clients. The therapist feeling comfortable with incorporating her voice in therapy was considered of utmost importance. This aspect alongside the therapist having a positive relationship with her voice and feeling connected to it were viewed and demonstrated as essential in the therapist's ability to effectively and efficiently apply this model.

Professional experience. A specific degree of professional experience in the music therapy field was not viewed as particularly necessary by this cycle's contributors in regards to incorporating the model in their work. Exposure to this model in the initial stages of a music

therapist's training, even as students, was thought to hold many advantages in relation to professional development.

Training. It was concluded that the degree of the therapist's comfort with using her voice in the therapy setting alongside her acceptance of her own voice must either be a prerequisite or an essential aspect included in the training of any therapist seeking to employ this model. Moreover, personally undergoing a vocal therapy process and the treatment of the therapist's own fear and anxieties were viewed as desirable in the preparation of the music therapist wishing to incorporate the vocal model. Simulations of voicework interventions representative of its various phases were found to be integral in learning, training and in fully understanding the model. Additional simulations than those allocated time for during the workshop presentation were requested by participants. Furthermore, gradualism in therapists' experiencing of the model's interventions and in incorporation of their own voice in simulations was believed highly necessary. This was particularly true for therapists not entirely at ease with incorporating their voice in therapy. Tailoring the model to specific clients' unique situations and connecting it to therapists' work in the field would require additional instruction and professional supervision.

Suitability to Populations

Emotional difficulties. Participants in this cycle strongly supported the notion voiced in the previous cycle that the model may be useful and effective with children with additional emotional issues outside of those with fears and anxieties. Application with such additional difficulties may require the model be subtly adjusted to suit the specific issues being treated. For instance, the phase of Vocal Confrontation with Fears, found to be highly specific for children dealing with fears and anxieties, may not be necessarily relevant when treating children for whom this is not an issue warranting treatment. It may therefore be concluded that

the VocaPlay model may be applied in therapy with children with a variety of emotional difficulties, following necessary adjustments required for each specific circumstance.

Additional populations. The studied model was further thought to potentially benefit a variety of additional populations and age groups, should appropriate alterations be made for each phase. Those mentioned during this cycle included youth with social anxiety, non-verbal children or youth, children and youth with cognitive disorders, physical disabilities, adults with vocal issues and group situations that integrate voicework with diverse populations. These options may be further investigated in future studies.

Relevance to Music Therapists

The modified and integrated model presented in this cycle was found by participants to be expansive, useful, effective and enjoyable. Key components mentioned as contributing to its overall effectiveness as a voicework model were: Structure and order, flexibility and fluidity, playfulness, incorporation of supportive techniques, and the integration of additional modalities. Each of the model's phases was found to contribute to the model's objectives in its own distinctive manner. Personal experiencing of its vocal interventions significantly contributed to its comprehensiveness and sense of transferability to other therapists' work.

Educating therapists in the VocaPlay model was believed to influence music therapists to incorporate more and varied vocality in their therapies in general and with children with emotional difficulties in particular. This was thought to be especially true for music therapists exposed to the model at the beginning stages of their profession and even as students. In these situations, being exposed to the vocal model was thought to encourage and validate increased use of the therapist’s voice at this crucial stage of their training. It was additionally felt to instill in them confidence in their voice and in its therapeutic facilitation in therapy. The voicework model was experienced as significant to contributing additional therapeutic tools that the beginning therapist may incorporate in her field work and in subsequent therapies. It was

further believed to raise the therapist's awareness and understanding as to the importance and role of the voice in therapy and to the vast possibilities inherent in voicework. Finally, this model brought to light the benefits and various possibilities inherent in working with and through the voice with a population that many therapists specifically tended to avoid incorporating vocality with: that of fearful and anxious children. Exposure to the VocaPlay model holds the prospect of changing this inclination, thereby expanding treatment options and offering a novel approach to the treatment of this population.

General Discussion

Foundation

The establishment of this model was based on the integration of the potent elements of vocality and playfulness, both found throughout this research to fundamentally contribute to therapy with the studied population. The result was the consolidation of the approach of vocal play incorporated throughout the study, lending the model its name of "VocaPlay Therapy".

Vocality. The medium of vocality was thought to be particularly appropriate for therapeutic interventions, as is a pre-verbal, innate and universal language shared by both the client and the therapist. As a personal instrument that all human beings carry within them and tend to regularly express themselves through, vocality is also readily available, and naturally emotionally expressive. As its use was found to be generally experienced as pleasurable by children, it was thought to contribute to cooperation in the therapy setting. Vocal interactions, especially when playful, are additionally reminiscent of a child's earliest form of communication with its primary caregivers. As such, these interactions hold therapeutic potential, possibly contributing to the therapist-client relationship, while creating a familiar, relaxed, and non-threatening environment. Such an environment was deemed essential for emotional and expressive work with children with fears and anxieties. As voicework may aid in releasing both physical and vocal restrictions, it further possesses the prospective to reduce tension as well as to release the voice's expressive potential. The voice's ability to represent and to touch upon the anxious child's specific areas of difficulty or blockages was further focused on through this study.

Playfulness. The ingredient of playfulness was found to make this model highly relatable to the child. Play is as well a non-threatening and familiar medium to children, relevant to their areas of interest, in which they freely and naturally engage in. In this study, playfulness was suggested to aid in the uninhibited use of vocality and in the release and relief

of tension and anxiety in general. It was additionally found to contribute to the child's cooperation in therapeutic interventions, encourage client creativity and spontaneity, promote the formation and building of the therapist-client relationship, and advance enjoyment in therapy.

Implementing the VocaPlay Model

Much insight has been gained through this study's cycles that has aided in the development of the model and will assist in implementing it with clients and in training music therapists wishing to apply it in their work. All findings are based on the foundations of vocal elements and vocal phases developed in Cycle 1 and further revised and refined throughout Cycle 2 and Cycle 3.

Choosing clientele. Deciding which clients to apply the VocaPlay model with requires that the therapist exercise professional judgment and considerations based on knowledge of the client's diagnosis, therapeutic needs, personal preferences and inclinations. Most importantly, the therapist must be keenly aware of the client's responses and reactions and allow these to guide her when making this decision, not only initially, but also throughout the therapy process when considering continued use of the model.

This model was ultimately found be suitable for the intended population studied of children with fears and anxieties. This was the case regarding the use of playful vocality as a therapeutic medium and its gradual introduction to the therapy. The session structure, the model's overall approach, and aspects of concreteness within the model (as founded in Cycle 1), were additionally found appropriate for this purpose. Most importantly, the model's content was believed to meet the objectives relevant for this population. As an example, incorporating relaxing techniques, coping skills and helping children to identify and express their fears and emotions was thought to help manage and regulate their anxiety as well as other stressful emotions.

Following participants' observations in Cycle 2, revisions were made to make the model even more compatible to this population's unique needs. These revisions included clarifying boundaries throughout sessions as well as emphasizing elements of structure, repetition, imitation and familiarity in the initial stages of therapy. They also included expanding the initial pre-vocal phase to include additional elements to aid in tension reduction and increased gradualism toward the introduction of vocality.

Overall, clientele believed to benefit the most from the model formulated included:

- Children suffering from fears and/or anxieties
- Children with vocal and speech disorders related to emotional issues
- Children for whom the voice is their preferred therapeutic medium
- Children with emotional difficulties that may be met through voicework

Forms of application. Different options for application of the model for therapists wishing to implement the model in their clinical work were raised throughout the cycles. These include: Applying the entire model or appropriate phases from it in a systematic manner to obtain a voicework process (full application), adding choice voicework phases or stages to a pre-existing therapy process (partial application), and borrowing techniques, tools or concepts from the model as needed (occasional application). These options allow for the model to be applied in an even more flexible manner, in accordance to the specific and emerging needs of the client. They may further make aspects of the model accessible to more therapists, such as to those in related disciplines, and contribute to enriching their work.

Non-vocal elements. Elements of a non-vocal origin incorporated in this model were found throughout this model's cycles to influence the child's vocality and interactions with the therapist in a variety of ways, often contributing to the voicework process. When implementing this model, thought and professional judgment must therefore be used when applying non-

vocal elements to vocal interventions. Non-vocal elements discussed and elaborated on throughout cycles include:

- Accessories. Such as visual images, graphs, scarves, balls, balloons, soap bubbles and more.
- Musical instruments. Especially instruments that may promote breathwork and vocality (wind instruments, the kazoo, microphone), stimulating instruments to assist in the expression, release and catharsis of fearful emotions (various drums and percussion), instruments of a calming nature that may add reassuring order and harmony (autoharp, guitar, lyre, etc.), and instruments that may mimic feared stimulants and allow the client to gain a sense of control over them (a slide whistle may be reminiscent of an ambulance, a thunder tube may sound like thunder or a roar, etc.).
- Additional creative modalities. These mainly include art, drama, movement, and storytelling.

General guidelines. Throughout Cycle 2 and Cycle 3, aspects were raised that proved essential to therapists' comprehension and potential application of the model. Participants' statements elucidated the necessity to clarify that this model is not intended to be used in an overly formulaic way and is in no way a recipe for voicework treatment with any client. Moreover, it may not be appropriate to apply this model with every client or at every stage of therapy. Rather, it is obligatory that the therapist exercise professional judgment throughout, sensitively adjusting application in accordance to each client's unique situation, needs, responses, relationship with the therapist, and rate of progress within the therapy process. Additional aspects to consider include the client's traits and emotional, developmental and cognitive level. Furthermore, the importance of gradualism within the application of therapeutic interventions and among the model's phases is a topic that was found to require

repeated reiteration. Understandings following these clarifications should serve to combat misperception of the model and improve its clinical application.

Defining the therapist. When considering the therapist that the VocaPlay model may be most relevant to, questions rose regarding the therapist's professional orientation, vocal background, vocal abilities and professional experience. These queries were accounted for through this study's cycles and led to conclusions regarding the background and training of therapists wishing to incorporate this model in their clinical work.

Professional orientation. Given the multifaceted role of the therapist in this model, it was viewed as an advantage by Cycle 2 contributors that the VocaPlay therapist come from the field of music therapy, as music is the main language of this model. Music therapists would also most likely possess more awareness as to the musical aspects inherent in a client's vocality and their possible implications. However, the concept was raised that emotional therapists from additional fields that felt a strong connection to their voice and comfortable using it in their therapies may also be likely candidates for learning this model. It was additionally suggested that emotional therapists from any field may easily borrow selected techniques from the VocalPlay model and incorporate them in their existing therapies.

The therapist's vocality. The consensus arising from Cycle 2 and Cycle 3 was that it was not necessary for the music therapist to be a singer, or even for the voice be the therapist's main instrument, in order for them to successfully apply the VocaPlay model. Though it was generally suggested that the therapist have some previous vocal training in order to be capable of effectively applying this model, it was thought possible that the therapist come from diverse vocal backgrounds. These may include voice development lessons, vocal improvisation courses/workshops, vocal performance experience or even undergoing a voicework process themselves.

It was suggested in Cycle 1 that the therapist should be able to vocally improvise and to use her voice in a flexible, playful, expressive and uninhibited manner, while listening closely to the client's vocal expression and adapting herself to the client's emotional needs. Such abilities may allow the therapist to best apply the model's various voicework techniques, model therapeutic uses of the voice, and to encourage and legitimize the client's vocality.

However, it became apparent in the following cycles that being able to do so was above all contingent upon the therapist's relationship with her voice. Above all, the determining factors revealed to be essential in effectively and efficiently applying this model was that of the therapist's acceptance of her voice and degree of comfort sounding her voice in therapy. Findings in Cycle 3 consolidated those in Cycle 2 regarding this discovery and how music therapists' attitudes towards voicework, specifically their own voice, influence their willingness and ability to incorporate their voice in therapies. The human voice appears to be the closest and most intimate instrument you can choose as a client or as a music therapist. Therefore, when choosing the voice as a primary instrument in music therapy, an awareness towards this matter and its possible implications must be considered carefully.

Professional experience. This research concluded that the VocaPlay model could be applied by music therapists with varying experience. This included music therapy students with limited field work experience, as well as highly experienced music therapists. For experienced therapists, this model was believed to enrich their therapies and expand their toolbox. For beginning therapists, exposure to this model was thought to organize and clarify uses of the voice in therapy, make voicework more accessible to them, and allow them to incorporate their voice in an increasingly confident manner in their therapies.

An unsuspected discovery was that inexperienced music therapists appeared to possess an advantage over their more experienced colleagues in regards to the openness and flexibility of their attitudes in relation to using their voice in diverse manners in general and in applying

voicework in their clinical work with anxious and fearful children. This was the case even among those beginning music therapists who initially reported lacking confidence in their vocal abilities and feeling uncomfortable incorporating vocality in their therapies.

Training the VocaPlay therapist. As this research found the model established through Cycle 1 and Cycle 2 to be generally applicable and adaptable by additional music therapists (Cycle 3), the question arises as to how best train a therapist in the VocaPlay model.

A training course relaying this model would expand therapists' knowledge of its foundations and applications throughout different situations that may arise in therapy and with diverse clientele. It would additionally advance awareness of the child's vocality during sessions and of the potential impact of playful vocality. This research emphasized how the manner in which the model is implemented affects its effectiveness. This was observed during the personal experiencing of vocal interventions in Cycle 3. Such simulations as well as the vocal demonstrations included in both Cycle 2 and Cycle 3 were found to play an integral role in accurately relaying the model and contributed to the model's sense of transferability to other therapists' work. Incorporated in a training course, these means would further familiarize therapists with this model's possibilities of application, offer reassurance and potentially increase the therapist's confidence. It is thereby viewed as essential that in addition to obligatory verbal instruction, training in this model would include experiential simulations alongside auditory demonstrations of such voicework. Additionally, professional supervision of therapists' clinical work with the clients they apply the model with would be necessary in order to consider ways to adapt the model to suit particular situations, clients, and unique needs or requirements that arise in each predicament, as well as direct on the model's correct application.

Such varied exposure of therapists to the model as described above may aid towards the achievement of flow and spontaneity in facilitation and in the therapist's increased sense of

confidence and ease when applying the model. This would contribute to the model becoming part of the therapist's easily accessible toolbox.

Additional therapist qualities and vocal abilities viewed as central to applying this model may be further developed through such a training program. It is considered most desirable that as a prerequisite for learning this model, the therapist be accepting of her own voice and feel comfortable using it in therapy, having previously addressed all related anxieties and insecurities. However, the ongoing and gradual experiencing of the VocaPlay model's techniques throughout training may as well afford therapists learning this model to undergo somewhat of a personal process themselves, as voiced by Cycle 3 contributors. This would involve their degree of comfort with their voice and release of their voice from inhibitions, while expanding its expressive possibilities and developing its potential. As concluded from Cycle 2, raising awareness to issues relating to the therapist's anxiety and other factors thought to inhibit her use of vocality would be particularly necessary, in order to prevent these matters from negatively impacting the therapist's application of the model. This would be particularly vital for therapists working with clients suffering from fears or anxieties.

While not a replacement for therapists that require undergoing therapy themselves for deep seated anxieties and personal issues, the experiences undergone throughout training in this model may meet the needs of certain therapists for a vocal process, as expressed by participants in Cycle 2 and Cycle 3.

Research Contribution

As with prominent existing voicework models in the professional literature, the VocaPlay model examines incorporating voicework towards therapeutic ends, with an emphasis put on the role vocality may play in the client's overall process. As this model draws inspiration from existing voicework models, it is partially founded on voicework concepts depicted in the literature and shares certain vocal techniques.

The VocaPlay model's distinctiveness is evident in its objectives and in its novel approach to the treatment of a population not commonly regarded in the voicework literature. A minority of the existing voicework models, based on case studies, may indeed be appropriate for certain children, albeit with cognitive, neurological or developmental difficulties (Uhlig, 2011a, 2011b; Warnock 2011). These models do not consider verbal processing necessary. Dissimilarly, the VocaPlay model is geared towards children with intact cognitive functioning, whose challenges are primarily emotional. Verbal processing is considered necessary for therapeutic progress in this model, especially in the more advanced stages of the therapy. It is further geared towards the condition of fears and anxieties in children, a predicament not previously undertaken by existing models.

The researched model additionally combines vocal objectives with emotional goals. It may thereby serve to edu

cate therapists on the correlation between emotional disturbances and their vocal manifestations in children, and open up the option for music therapists to treat children with vocal and speech manifestations rooted in anxiety. This may include conditions such as selective mutism, stuttering, vocal tics, unregulated vocal dynamics, and additional abnormal vocal manifestations not previously targeted in the voicework literature.

The VocaPlay model is highly structured and suits the application of vocal elements, vocal techniques, therapist's vocal roles and therapeutic objectives to the client's stage of therapy. This model moreover incorporates a diverse toolbox of vocal techniques that integrate a variety of artistic modalities, including music, movement, art and drama. Further unique to this vocal model is its approach which is founded upon playfulness, viewed as an integral component in all voicework interactions.

The void of and hence the need for such a model was further emphasized by this study's findings: Even experienced music therapists stated that they did not feel they had a model to

refer to when working with children through voicework. When working with children with fears and/or anxieties, most therapists borrowed concepts and techniques from other therapy fields. Beyond this, many harbored reservations regarding the use of vocality with this particular population. These circumstances led to therapists both limiting their use of voice in therapy, lacking confidence when applying vocality, and at times avoiding use of vocal interventions altogether. The development of the VocaPlay model through this study may educate music therapists as to the many uses and forms vocality may have in work with verbal children of intact intelligence in general, and to the benefits voicework may have with fearful and anxious children in particular. It may therefore challenge the stigma that even experienced music therapists were frequently found to attach to voicework with the latter population. It may additionally encourage music therapists to incorporate more voicework with children in general.

Having a structured and concrete model to refer to may further allow therapists to incorporate their voices and vocality in their therapies with children in a more assured manner. It may additionally serve to increase their confidence in clinical work with children suffering from fear and anxiety.

Exposure to this model in early stages of a music therapist's training may potentially contribute to an increased use of vocality in their therapies, and prevent the tendency towards avoidance of voicework or of vocal rigidity from developing in future generations of music therapists.

The change promoted in this research is a change in the practice of voicework with children with fears and anxieties, therefore expanding the treatment options available to this population. The development of the studied model strives to further the professional advancement of music therapists, leading to more proficient therapeutic voicework with this population, as well as expanding the variety of therapeutic tools available to music therapists.

In this way, the study seeks to create a change in the field of music therapy and to contribute to its professional development in society. The research ultimately hopes to contribute to society by improving the quality of life of those who may be aided by the model developed through this study.

Research Constraints

Several restrictions exist in the current study:

- This study was conducted in Israel. All contributors had studied or were studying at the time of participation in music therapy programs in Israel, and worked with clientele residing in this country. As such, results may be reflective, in part or in entirety, of this country's culture.
- Though thought to be representative of the contributors sampled, this research was nonetheless conducted with a limited sample size of participants in each cycle.
- Contribution to the development of the initial model was restricted to two specific groups of co-researchers (experienced music therapists and music therapy students in their second year of studies), thereby limiting the perspective represented in this study.
- The present study did not allow for the implementation of the model by music therapists in their clinical work or for the supervision of such work.
- For practical and technical reasons, contributors to Cycle 2 and Cycle 3 were presented with a relatively concise version of the model which summarized its main points and positions. Audio demonstrations were also generally limited to one technique and scenario per phase out of numerous options. Likewise, the simulations offered to participants in Cycle 3 were limited in number and in duration.

- Focus group participants were not afforded time to undergo more gradualism in their learning and experiencing of the model as would have been ideal.
- Voicework simulations were conducted with participants among themselves. They therefore did not have the opportunity to experience any of the model's techniques with actual clients or within the framework of an actual therapy session.
- The scope of this research did not permit the investigation of the model's application with the additional populations suggested.

Future Research

Several subjects arose through this research that may be investigated in future studies. Conclusions emerged from Cycle 2 and Cycle 3 regarding the suitability of the VocaPlay model for treating additional emotional disorders in children besides fears and anxieties. Thus, future research may further examine the model's appropriateness for children with emotional issues in general.

The potential benefit of applying the model either fully or partially with additional conditions and age groups as suggested by contributors throughout this study may also be further investigated. This would necessitate making alterations to the model according to the unique circumstances of each population treated. These may include children or youth who are non-verbal or suffer from cognitive or physical disorders, youth with social anxiety or vocal issues, and group situations that integrate voicework with diverse populations.

The possibility that therapists from additional disciplines may implement this voicework model either fully or partially under specific conditions as suggested by participants may be additionally investigated.

A notion was raised through this study that addressing the issue of voicework early on in the training of music therapists may yield a generation of music therapists that feel more

comfortable incorporating vocality in their work in comparison to their more experienced peers. This is a theory that may be warrant further research.

Applying the conclusions and theory that evolved through this research into practice and conducting a VocaPlay Training Course for music therapists, during which the model and its applications in the field would be further examined and evaluated, may continue to contribute to the development of this model.

Lastly, investigation into the vocal assessment of children with fears and anxieties holds the potential to be a welcome contribution to the field of voicework in general and to voicework with this population in particular.

Concluding Remarks

The research conducted in this paper has served to reach this study's objective of developing a voicework model suitable for children suffering from fears and anxieties. Through three cycles of participant cooperation and contribution, the methodology of AR employed throughout this work contributed to the model's increased versatility, efficacy, and adaptability to clients' needs, beside its relevancy and applicability for music therapists.

In this model, emphasis was placed on the importance of the therapist’s vocal role in implementing vocality in a sensitive manner, adjusted to the child’s responses and developing needs throughout. This vocal role (and subsequent ensuing interaction with the child) appears to accurately correspond to the response of the affectively attuned or empathic caregiver to the infant, as defined by Stern’s theory of affective attunement (1985). Accordingly, caregivers naturally respond interactively to an infant’s non-verbal vocal sounds through their own vocality. From a child’s birth, musical aspects of his vocality are naturally imitated, extended, developed or exaggerated by their caretakers. Such sensitive and resonating responses are further believed to create a context of intersubjective resonance (Malloch, 1999; Malloch & Trevarthen, 2009; Trevarthen, 1998). They do so by reflecting back the infant’s emotional state

that corresponds to his expressions and by assuming the role of a "biological mirror" (Papoušek, 1995) or of an "amplifying mirror" (Schore, 1994). The significance of such empathic responsiveness has been discussed at length by several psychoanalytic theorists (such as Lacan, Bion, Mahler, Kohut and Winnicott). In this way, the voice provides a primary medium for interpersonal relationships and for human communication (Papoušek, 1996; Stern, 1985). This attuned response is additionally believed to contribute to the regulation of the infant's affects, states of arousal and behavior by calming the infant and restoring a tolerable emotional state (Schore & Schore, 2008; van der Kolk & Fisler, 1994). Musical elements present in these vocal interactions may further serve as a container which promotes a sense of safety and decreased anxiety (Uhlig, 2006). This attuned stance is therefore considered an aspect crucial to the successful implementation of the voicework model, as it may assist the therapist in calming the fearful and anxious child by modulating his arousal. The voicework described in this model is therefore thought to support the child's emotional development and regulation, alongside his social progress, promoting and improving aspects of his interactions with his surroundings.

The child's affective state was found to be reflected and communicated through varying musical aspects of his vocality throughout the therapeutic process in this model. The sound of the child's voice therefore appears to be an accurate outward expression and indication of his internal state. This finding supports existing theories on the intrinsically musical nature of human interaction and communication (Malloch, 1999, 2012; Malloch & Trevarthen, 2009; Trevarthen & Malloch, 2000; Trevarthen, 2008).

Existing works discuss the close connection between the experience of vocalization and the therapeutic relationship within the music therapy context (Nordoff and Robbins, 1977; Pavlicevic, 1997). Abovementioned studies additionally observe how vocal exchanges form the most initial forms of human interaction and communication (Stern, 1985, 2002, 2010).

When attuned to the child's developing needs throughout the therapeutic process, these aspects of vocality, paired with the intimacy generated by the very act of singing, appear to have contributed towards fostering and even hastening the initial trusting relationship that lies at the core of the therapeutic alliance with the child. This alliance and subsequent cooperation from the child were observed to be essential to the success of the voicework process studied. Stern's findings, which trace the origins of human vocality to the original caregiver-infant interaction, further contribute to the voice's relevance specifically in regards to therapeutic processes with children. This is due to their implications concerning the voice's ability to possibly replicate important aspects of the child's most influenceable relationship. Accordingly, the voice may further be used to repair early mother-child ruptures (Trevarthen, 1980; Winnicott,1971). The period of childhood is unique in that children have often not yet strayed far from either their initial relationship with their voice or from such primary and influencing vocal experiences. Therefore, childhood may provide a key opportunity for clients to realize the many benefits therapeutic voicework may offer.

The VocaPlay model combines the therapeutic mediums of voice and play. The functions of 'play' in a child's life are thought to include: Promoting emotional development, establishing a sense of self, assisting in the formation of relationships, and serving as an early form of communication with oneself and with others (Bratton & Ray, 2000; Russ, 2004; Winnicott, 1971). The environment provided by the caregiver through play allows the infant an experience of being held both physically and psychologically. When these advantageous attributes of play are paired with the many aforementioned benefits of voicework, they further contribute to the perceived value of the VocaPlay model as an influential therapeutic tool in the treatment of children with fears and anxiety.

From a personal perspective, this research allowed me to respond to an evident clinical need that had emerged through my work and was felt to be of therapeutic importance: The need

for a voicework model for children with primary emotional issues. This study helped me reflect on my work and experiences as a music therapist. Researching and developing this voicework model have permitted me a unique opportunity to deepen my understanding of the various ways in which voicework may be used as a significant agent of change when applied in a therapeutic context. Applying the VocaPlay model in my work has allowed me to experience and to witness first-hand the powerful therapeutic impact that voicework in music therapy can have. This paper signifies the culmination of nearly two decades of therapeutic practice specializing in voicework in the profession of music therapy. It is my hope that this study may make a valuable contribution to the field of music therapy, assist music therapists in their practice, and ultimately benefit clients.

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Appendices

Appendix A

Table 1

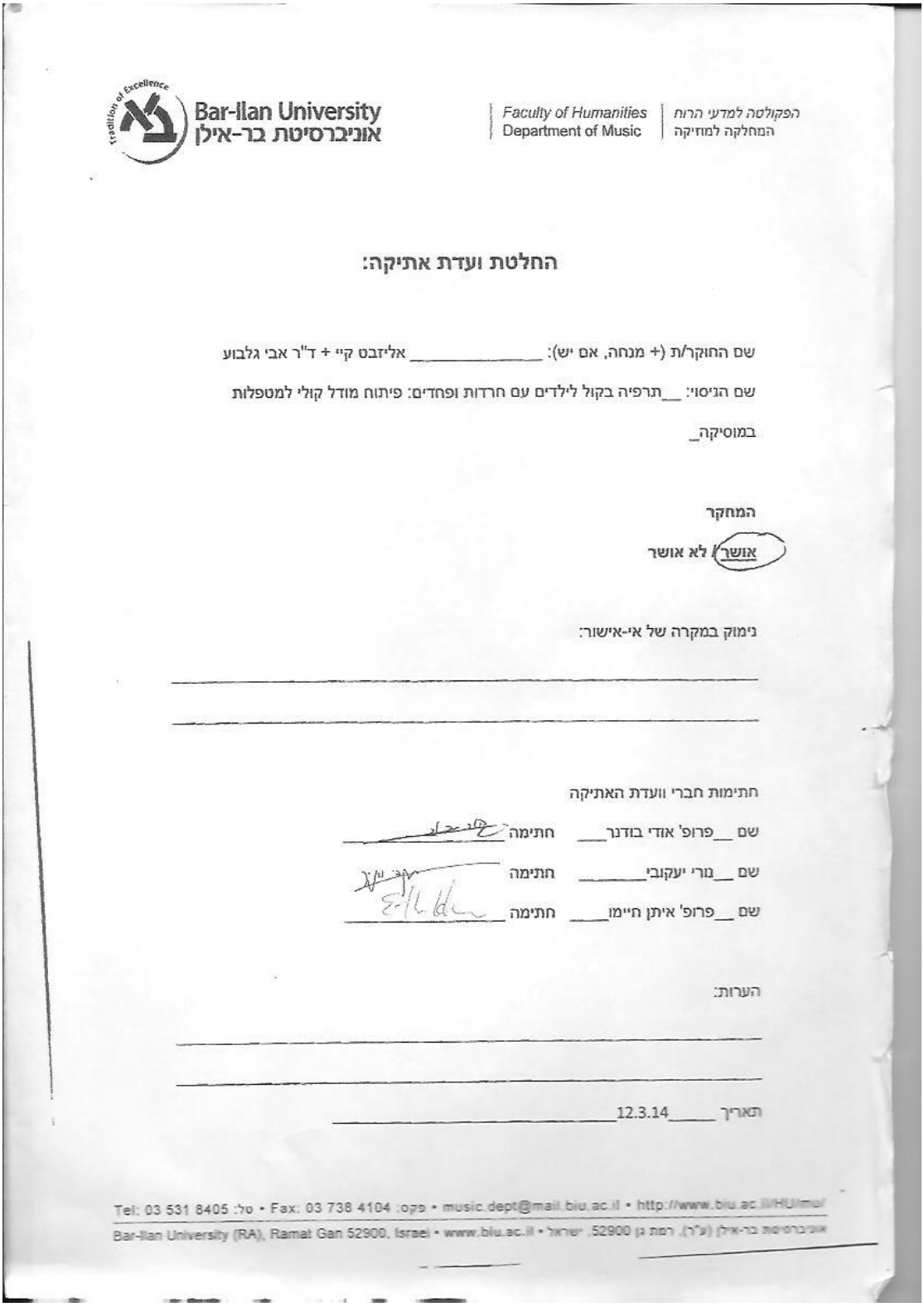
Summary of Therapeutic Voicework Models

Name of vocal model	**Embodied Voice Work**	**Voice Movement Therapy**	**Vocal Psychotherapy**	**Contingent Singing**	**(unknown)**	**Rap Music Therapy**
Originator	Lisa Sokolov	Paul Newham	Diane Austin	Helen Shoemark	Tina Warnock	Sylka Uhlig
Age groups	Adults	Adults	Adults and adolescents	Infants (40 weeks' gestation)	"All ages"	Children and youth (5-12)
Clinical population	Verbal and intelligent, emotional problems, psychiatric problems, pain sufferers, stroke and cancer patients, in childbirth.	Emotional problems, trauma victims, disease, mental and physical handicaps	Verbal and intelligent, emotional problems, trauma victims, attachment deficits, sexual abuse victims, eating disorders	Hospitalized newborn infants	Autism and learning disabilities with mental health issues	"At risk" African-American/Hispanics with special needs
Verbal processing	Necessary	Not always necessary	Necessary	Not necessary	Not necessary	Not necessary
Theoretical foundations	Gestalt therapy, Wilhelm Reich, Jungian psychology,	Alfred Wolfsohn, Roy Hart, Jungian psychology, Wilhelm	Jungian psychology, object relations theory (Winnicott), music	Stern's affect attunement, contingency therapy, mirror neuron systems,	Object relations theory (Winnicott), Stern's "layered self"	Entrainment, flow theory

	Neurolinguistic Programming, ideokinesiology, healing traditions	Reich, Paul Moses, ancient healing traditions	psychotherapy, depth psychology, trauma theory, addiction treatment, intersubjectivity	pattern of expectation model	theory, Jungian psychology	
Vocal techniques	Improvisation, free vocalization, singing, toning, breathing, vocal interactions	Singing pre-composed and personal songs, breathing, improvisation, free vocalization, primal vocal sounds, vocal exploration, vocal development	“Vocal holding techniques”, “free associative singing”, breathing, singing, improvising, toning, chanting, natural sounds	Singing, humming, chanting, improvised vocalizations, nonsense lyrics, repetitive melodic themes, semi-sung motifs	Singing, pre-verbal vocalizations, nonsense lyrics, call-and-response techniques, lyric improvisation	“Primal sounds" (rapping, singing, shouting), improvising vocal patterns and lyrics, call-and- fill-in-the-response and blank techniques
Therapeutic aims	Awareness, expression, release of blockages/holdings, access subconscious materials, stress and pain reduction, neurological stimulation	Freeing vocal function from constriction, developing vocal expressivity, liberating the “authentic voice”	Repairing early mother-child ruptures, ego integration, emotional expression, catharsis, sublimation	Neuropsychological development, self-regulation, interpersonal relating.	Development of self and identity, interpersonal relating, self-awareness, and voice development	Aggression regulation, raise self-esteem, neurological stimulation

Appendix B

Ethical Committee Approval



Bar-Ilan University
אוניברסיטת בר-אילן

Faculty of Humanities
Department of Music

הפקולטה למדעי הרוח
המחלקה למוזיקה

החלטת ועדת אתיקה:

שם החוקר/ת (+ מנחה, אם יש): _____ אליזבט קיי + ד"ר אבי גלבוע

שם הניסוי: __תרפיה בקול לילדים עם חרדות ופחדים: פיתוח מודל קולי למטפלות במוסיקה_

המחקר

אושר / **לא אושר**

נימוק במקרה של אי-אישור:

_____

_____

חתימות חברי וועדת האתיקה

שם __פרופ' אודי בודנר___ חתימה _____

שם __נורי יעקובי_____ חתימה _____

שם __פרופ' איתן חיימו____ חתימה _____

הערות:

_____

_____

תאריך _____12.3.14_____

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Appendix C

Parental Consent Form

<u>טופס הסכמה מדעת: אישור הורים להשתתפות ילדם במחקר</u>

אני הח״מ:

שם משפחה: _____ שם פרטי: _____ מס׳ ת.ז. _____

כתובת: _____ מיקוד: _____

א. מצהיר/ה בזה כי אני מסכים/ה שילדי/ילדתי ישתתף/תשתתף במחקר כמפורט במסמך זה.

ב. מצהיר/ה בזה כי הוסבר לי ע״י:

שם החוקרת: _____ כדלהלן:

כי המחקר נערך בנושא: טיפול באמצעות קול בקרב ילדים עם חרדות ופחדים.

כי אני חופשי/ה להפסיק בכל עת את השתתפות ילדי/ילדתי במחקר.

כי המחקר מחייב הקלטות אודיו במסגרת הטיפול הרגשי.

כי יעשה שימוש בתוצרים האומנותיים של הילד/ה במסגרת המחקר; הקלטות, שירים שנכתבו/הולחנו, ציורים, יצירות אומנות, חומר כתוב.

כי מובטחת סודיות מלאה באשר לזהותי האישית ולזהות ילדי/ילדתי במהלך המחקר ופרסומים מדעיים.

כי נדרש שיתוף פעולה מציד בעדכונים שוטפים באשר למצב ילדי/ילדתי והתקדמותו/ה ו/או נסיגותיו/יה במהלך ההשתתפות במחקר.

כי בכל בעיה הקשורה למחקר אוכל לפנות לחוקרת להתייעצות נוספת.

ג. הנני מצהיר/ה כי נמסר לי מידע מפורט על המחקר ובמיוחד הפרטים הבאים הקשורים: למטרות המחקר, לשיטות, למשך הזמן הצפוי, לסיכונים הטמונים הנפוצים ולאי-נוחות העלולה להיגרם.

ד. הנני מצהיר/ה בזה כי את הסכמתי הנ״ל נתתי מרצוני החופשי וכי הבינותי את כל האמור לעיל.

_____	_____	_____
שם ההורה	חתימה	תאריך

ה. הצהרת החוקר/ת

ההסכמה הנ״ל נתקבלה על ידי וזאת לאחר שהסברתי לנותני אישור ההשתתפות במחקר את כל האמור לעיל ווידאתי שכל הסבריי הובנו על ידו/ידה.

_____	_____	_____
שם הסטודנט/החוקר	חתימה	תאריך

Appendix D

Table 5

Summary of Notable Vocal Interventions in Case Studies

Case Study 1

Int. no.	Session	Name of intervention	Description of intervention	Vocal technique	Insights/rationale	Materials	Category
1	2-4	Vocal accompaniment	I vocally improvise to Shira's free dancing movements and to her drawing strokes. She initially reacts by smiling, by varying her movements and by scribbling. She eventually suggests we switch roles and begins to (loudly) vocalize to my movements and sketches.	Vocalizations (therapist/client)	Adding a vocal element to the sessions by modeling vocal improvisations (this manages to prompt Shira to improvise vocally)	Movement, scarves, crayons	Pre-vocal (vocal modeling, vocal prompting)
2	3-4	Free microphone vocalizations	When I hand her the microphone, she begins vocalizing freely into it: Loud staccato shouts, some scary voices and laughter ensue. She adds the clashing of cymbals to these vocalizations. She then passes the microphone to me, requesting I do the same.	Free vocalization	Free microphone use as a diagnostic tool, prompting vocalizations	Microphone (audio recording)	Pre-vocal (vocal prompting)
3	2-6	Turn-taking vocalizations	After vocalizing into the microphone I pass it to her, encouraging mutual turn-taking improvised vocalizations.	Vocalizations (turn- taking)	Encouraging vocal interaction (She turns these into familiar tunes, all of them loud and rhythmic. She avoids touching upon	Microphone (audio recording)	Vocal togetherness (vocal interaction) Pre-vocal (prompting)

					softer or more gentle voices. She does however become more attentive through throughout).		
4	4-6	Vocal waves	She sings into an audio recording program which visually indicates the volume of her voice on a screen through waves and begins to make some attempts to lower her vocal volume, checking though the program if she is indeed successful in doing so.	Singing pre-composed songs (vocal ingredient: volume)	Vocal volume awareness	Audio recording program, microphone (audio recording)	Vocal modification/ vocal awareness (volume)
5	5-6	Volume graphs	We vocally improvise on volume graphs we create for each other.	Vocalizations (Playful vocality) (on volume)	Experiencing different degrees of vocal loudness	Volume graphs	Vocal modification (volume)
6	6-7	Volume games	I play familiar songs on the piano in varying volumes and she joins in singing with them according to the volume played. She switches roles by choosing automatic songs on the synthesizer I must sing to while she controls the volume of the songs played.	(Playful vocality), singing pre-composed songs (with volume)	Experiencing different degrees of vocal loudness	Piano, synthesizer	Vocal modification (volume)
7	5-6	Rhythmic dancing	We vocalize to each other's and then to our own free, disorganized movements and to more structured rhythmic movements.	Vocalizations (rhythmically structured/ unstructured)	Incorporating the structuring and calming benefits of the rhythmic component	Movement	Vocal structuring

8	5-6	Syllabic drumming	We conduct a conversation while drumming out the syllables of our words.	Rhythmic speech	Structuring speech to assist in stuttering, raising awareness to accelerated rhythm of speech (seems to moderate her stuttering throughout intervention).	Darbukas	Vocal structuring
9	6-10	Rhythmic speaking	We play a continuous simple rhythm on the darbukas at a medium speaking tempo. To this we add conversational speech. She is encouraged to originally set the tempo according to how fast she thinks her speech should be.	Rhythmic speech	Structuring and slowing down tempo of speech to improve stuttering (she tends to accelerate any given tempo, however this intervention aids in moderating her speaking tempo for the remainder of the session and seems to calm her).	Darbukas	Vocal structuring
10	7-8	Rhythmic improvisations	I improvise a basic accompanying vocal rhythm which Shira vocalizes above. We initially add rhythmic instrumental accompaniment to these improvised vocalizations but later do without.	Rhythmic vocalizations (mutual)	Incorporating the calming and structuring benefits of the rhythmic component (she manages to focus on her vocal role and to improvise according to the set rhythm throughout)	Percussion instrument accompaniment	Vocal structuring
11	4-8	Holding a note	Slower, calmer breathing was encouraged by throwing scarves between us while holding a note on	Toning	Promoting deeper breathing	Scarves, crayons	Breath exploration (relaxing

			one breath until the scarf reached the other and by drawing parts of a picture while holding a draw-out note. Whenever she took a breath, she would be required to switch the color she would be drawing with.		(This was especially helpful at the beginning of sessions and aided in calming she and in regulating her tempo of speech).		deep breathing)
12	6-8	Blowing bubbles	She was encouraged to attempt to blow as many soap bubbles as possible in one breath.	Breathwork	Promoting deeper breathing	Soap bubbles	Breath exploration (relaxing deep breathing)
13	6-7	Singing dolls	We sing songs to dolls which visually display different emotions (crying, smiling, frowning, sleeping dolls…), while varying our vocality accordingly to their perceived emotion: Singing a cheerful tune to a "happy" doll while making it dance, singing a soft lullaby to a "sleeping" doll while rocking it back and forth, singing in a sad voice to a tearful doll while embracing it…	Singing (pre-composed, emotions)	Encouraging the expression of various emotions through vocality	Dolls (audio recording)	Vocal emotional expression (varied)
14	7	Vocal response song	We sing a vocal response song surrounding emotions: "How does the doll sing when she feels happy/sad/angry/scared". I accompany on piano with chords as she responds vocally with emotionally varying "la la la" singing while freely improvising on the piano's high notes.	Singing (emotions)	Vocal expression of different emotions (This is first modeled)	Piano, doll	Vocal emotional expression (varied)

15	7-8	Melancholic melodies	We integrate more melancholic melodies into improvised vocalizations by vocally improvising melodies inspired by pictures she would spontaneously draw, such as a gloomy, rainy day.	Vocalizations (on drawings, mutual)	Vocal expression of difficult emotions.	Drawings	Vocal emotional expression (sadness)
16	7-8	Vocal dedications	Alongside familiar songs, we dedicate vocalizations of varying emotion to her mother: Sad, frightful, hopeful and joyful. Shira chooses accompanying instruments accordingly.	Singing, vocalizations (emotions)	Vocally expressing emotions regarding her mother's condition.	Varied accompanying instruments (audio recording)	Vocal emotional expression (mainly sadness, fear)
17	8-10	Vocal containment	I adopt a supportive, containing vocal role throughout her vocal improvisations, mostly holding grounding notes beneath her improvised vocal melodies.	Vocalizations/ Vocal containment (therapist)	Legitimizing, containing and supporting emotionally significant improvisations (This seemingly aids her in remaining longer with improvisations, including those of a calmer and more solemn nature).	_____	Vocal emotional expression (legitimization, containment)
18	9-13	Singsong speech	We combine singing with verbal expression by carrying on long, spontaneous conversations incorporating singsong speech.	Singsong speech	Combing singing with verbal expression, Improving her ability to make herself verbally understood though incorporating vocal fluency qualities into her speech to improve stuttering (During these	Microphone	Vocal modification (fluency), Vocal emotional expression (verbal)

					her voice would be fluent and her words clearly understood. No stuttering could be detected)		
19	7-8	Vocal dedications	Alongside familiar songs, we dedicate vocalizations of varying emotion to her mother: Sad, frightful, hopeful and joyful. Shira chooses accompanying instruments accordingly.	Singing, vocalizations (emotions)	Vocally expressing emotions regarding her mother's condition.	Varied accompanying instruments (audio recording)	Vocal emotional expression (mainly sadness, fear)
20	10-14	Conversational improvisations	We add lyrics to emotional melodic vocalizations and they take on a sing-song conversational nature. Though these she begins to express fears and misconceptions surrounding her mother's condition.	Conversational vocal improvisations (mutual)	Verbally expressing emotions and personal perceptions regarding her mother's condition. (The conversational format of these improvisations allowed me to calm her fears through the soothing melody, reflect lyrically and melodically on her expression as well as verbally reassure her and clarify her misunderstanding regarding her mother's situation. Shira enjoys subsequently listening to recordings of these improvisations).	Microphone (audio recordings)	Vocal emotional expression (verbal)

21	11-13	Communication songs	I relay information she has difficulty processing concerning changes by incorporating relevant information into improvised songs. She appears to listen intently to these songs, later posing questions pertaining to certain lyrics.	Vocal improvisation (therapist)	Relaying important information in a manner she could better process, understand and accept (seemingly both cognitively and emotionally)	Guitar (accompanying instrument)	Relaxation (information processing)
22	13-14	Recording revisiting	She requests to revisit songs recorded throughout therapy. We review through them how her voice transitioned from painfully loud at times to pleasant and tender.	Listening	Vocal awareness and summarizing process.	Audios recordings	Vocal awareness/ vocal image (summarization)
23	14-15	Vocal summarization	We sing about what she'll remember from our time together and what she thinks I'll remember from her and feelings surrounding saying goodbye	Vocal improvisation (mutual)	Processing the farewell	_____	Vocal emotional expression (verbal, sadness) (summarization)
24	15	The new voice	We improvise a song about her newfound voice, sung with the qualities she attributes to it: Nice, gentle, "not nervous", "sometimes sad".	Vocal improvisation (vocal qualities)	Supporting and promoting her more emotionally integrated and genuine voice.	_____	Vocal image (summarization)

Case Study 2

Int. no.	Session	Name of intervention	Description of intervention	Vocal elements	Insights/rationale	Materials	Category
1	1	Vocal togetherness	Noa sings a song spontaneously into microphone and I accompany her with my voice.	Singing together, vocal containment	Forming a relationship through voice	Microphone	Vocal togetherness
2	2-5	Emotional song accompaniment	Noa accompanies my singing of the greeting song in a variety of emotions with appropriate guitar strumming, fitting her strumming to the emotion portrayed in the song.	Emotional singing	Legitimization of variety of emotions (Noa cooperates except for when the emotion portrayed in the song is "sad". Here she stops abruptly and claims she doesn't know how to play).	Guitar	Vocal togetherness, Vocal emotional expression (touching upon emotions)
3	2	Sounding emotions	We play different types of "winds" on an ocean drum she chooses, while accompanying the sounds with our voices, making whishing sounds according to the type of wind she wishes to portray.	Primary sounds	Touching upon emotional blockages. (When I suggest an angry wind, Noa stops playing and moves to the drum set to once again play the "monster" game).	Ocean drum	Vocal togetherness, Vocal emotional expression (emotional blockages)
4	2-4	Singing a story	We improvise a story through song while passing the microphone between us. The story that fist forms is about a girl who sings and plays	Improvised story-singing	Forming a relationship and touching upon emotional issues.	Microphone	Vocal togetherness, Vocal emotional expression

			music and is applauded and praised for doing so.		(Noa mostly repeats my singing and words)		
5	4-5, 17	Kazoo conversations	Kazoo conversations between us on a variety of emotions.	Kazoo conversations	Legitimization of emotional expression. Touching upon emotional blockages.	Kazoo	Vocal togetherness, vocal emotional expression (blockages)
6	4-6	Gibberish conversations	Noa improvises a sing-song gibberish conversation with me, at times accompanying herself on a darbuka.	Gibberish (mutual)	Encouraging vocal dialogue, vocal liberation and varied vocal expression. (Noa's expression develops throughout these gibberish conversations, peaking at final session).	Darbuka	Vocal togetherness, vocal liberation
7	5	Singing sad	Noa now agrees to sing songs of a more melancholic nature. Direction is given to assist her in finding a suiting voice for this newly expressed emotion.	Emotional singing (vocal ingredients)	Vocal expression of previously blocked emotion.	Pre-composed songs	Vocal emotional expression (sadness)
8	6, 10	Meowing emotions	She puts on a play in which she's a frightened kitten and communicates through cat sounds. She gives me the comforting role of mother cat. She then chooses emotion cards that characterize that kitten and meows in a voice that fits her choices.	Animal sounds	Expressing emotions through non-threatening animal sounds. (Plays she's a kitten who's lost her mother, frightened of thieves and noises,	Emotion cards	Vocal emotional expression (varied)

					and the mother cat feeds her, calms and protects her and sings her calming songs. The emotion cards she chooses to characterize the "kitten Noa": babyish, sad, disappointed, frightened.)		
9	7	Vocalizing emotions	Following touching upon sadness through storytelling singing, Noa draws a sad and a "mean" face, explaining the mean one doesn't want to play with the sad one. She chooses instruments for them and vocalizes sounds of crying and of growling while playing the instruments, according to the emotion portrayed. I improvise a song on the emotions while she does so.	Reflecting through song (therapist), primary sounds (client)	Vocal expression of previously blocked emotions.	Drawings, instruments	Vocal emotional expression (sadness, anger)
10	8-10	Singing fears	We improvise songs on her fears: Hail, darkness and monsters.	Vocal improvisation of songs (mutual)	Reflecting fear and confronting fears through song	Guitar (accompaniment)	Vocal confrontation of fears
11	8-9, 11	Singsong play	We put on a singsong play in the dark with a flashlight during which we chase away monsters, "shadows of darkness" or lions in the dark with our yelling accompanied by loud drumming.	Singsong speech (mutual), yelling, animal sounds	Confronting fears in a non-threatening playful way	Flashlight, drums	Vocal confrontation of fears, vocal empowerment

12	11	Characters in the dark	We put on a play in the dark in which she plays various characters, including monsters and a scared little child. She is encouraged to portray each character in a fitting voice that best suits it.	Character voices	Accessing different voices within her (scary, frightened, good, bad….). (This leads to a revealing storyline in which her fear of her parents' death is expressed).	Flashlight	Vocal image
13	10, 11	The angry voice	I assist Noa in discovering and sounding her "angry voice" as she sings songs in various emotions, including anger	Emotional singing	Vocal expression of previously blocked emotion.	Microphone	Vocal emotional expression (anger)
14	11	Reflecting songs	I improvise an "anger song" for Noa. She dances, jumps and plays drums loudly to the song. I encourage her to add yells of "ahhhh!" while doing so.	Reflecting through song, yelling	Encouraging varying expression of previously blocked emotion.	Movement, drums	Vocal emotional expression (anger)
15	12	Angry kazoo	Angry playing, argumentative conversations and yelling through the kazoo while accompanying herself on the gathering drum	Kazoo playing	More extreme expression of anger	Kazoo, gathering drum	Vocal emotional expression (anger), vocal togetherness
16	12-13	Angry beaters	Noa participates in a game of throwing beaters from afar at the drum set while yelling what angers her, completing the sentence "it bothers me when…."!	Yelling, speech	Vocal expression of anger (important information is revealed through her angry sentences).	Drum set, beaters, movement	Vocal emotional expression (anger)
17	12	Improvised fear song	After the subject arises, she plays the emotion of fear on synthesizer. I improvise a song above her playing with words pertaining to the emotion	Vocal improvisation (mutual)	Touching upon the (denied) emotion of fear.	Synthesizer	Vocal emotional expression (fear)

			and Noa gradually adds some sentences of her own.				
18	13	Scaring monsters	Noa chases away monster puppets with loud playing on darbuka and yelling.	Yelling	Confronting fears in a non-threatening playful way.	Drabukas	Vocal confrontation of fears, vocal empowerment
19	14	Emotional voices	Sings a holiday song according to different emotions, including fearful, scary and angry.	Singing (different voices)	Vocal expression of difficult emotions.	Microphone	Vocal emotional expression (varied)
20	13-14	Scary story improvisation	I improvise background music for a "scary story" on the piano and Noa decides to sing a story above it of girl who came home and found that nobody was there to open the door for her.	Improvised story-singing	Expressing fears through emotional storytelling supported by improvised mood music. (Continues in following sessions storytelling with motifs of good and evil and dying animals).	Piano accompaniment	Vocal emotional expression (fear)
21	15	Song dialoguing	Through turn-taking vocal improvisations with words Noa begins to reveal her fears concerning her parents dying and through this song dialogue mentions that both her parents were at the hospital and take medications.	Vocal improvisation (mutual turn-taking)	Dialoging on topic of specific fears through song as a substitute to straightforward speech.	Microphone	Vocal emotional expression (fear)
22	15, 24	Punching fears	Punches punching bag strongly and with each punch emphasizes vocally	Yelling, speech	Direct expression and empowering confrontation of	Punching bag	Vocal emotional expression (anger

			something that frightens or angers her.		fears and angers. (Requests I stand behind the punching bag so she may pretend I'm some of the things she mentions while punching. Has difficulty stopping punching. Requests this intervention 9 sessions later.)		and fear), Vocal empowerment
23	15-1 7	Relaxing improvisations	While playing harps I lead Noa in a calming vocal improvisation with draw out sounds, requiring deeper breathing and breath control.	Mutual improvisation	Promoting ability of emotional regulation, breath control	Hand-held harps	Breath control (relaxation)
24	16-18	Goodnight song	While she improvises on the synthesizer, I begin vocally improvising a calming goodnight song, leaving spaces for her to join in. She continues by improvising such a song on her own, asking G-d to protect her from all the things she fears, while I accompany her on guitar. We record this song and copy it to a disc she may listen to before bedtime.	Vocal improvisation (mutual)	Expression of fears and attempt assist her in calming herself before bedtime (after reports from her parents of difficulty sleeping from fears). (reports she listens and sings the song before bedtime and that it helps her fall asleep).	(Audio recording) Accompanying instrument	Breath control (self-relaxation), Vocal emotional expression

25	16	Accompanying vocalizations	I play different types of emotional music on various instruments, while she joins in vocalizing accordingly on the microphone.	Vocalizations (client)	Expressing emotions vocally through improvisation.	Instruments, microphone	Vocal emotional expression
26	16-18	Singing Noa	We list her positive traits and incorporate them in an improvised song titled "Noa", adding more positive traits as the improvisation continues.	Improvised singing (partially scripted lyrics)	Accentuating her strengths in an attempt to improve self-image and allow her to begin touching on her difficulties (she suggests positive aspects pertaining mostly to her behavior. I later make a list of possible negative characteristics as well as ask her to circle the traits she feels she possesses. She circles all the negative traits.)	Characteristic list, guitar	Vocal empowerment
27	19-21, 25	Dedicating improvisations	I improvise songs I dedicate to different aspects in her: Noa the frightened/sad/ happy/nervous/angry. She listens closely while accompanying accordingly on the trumpet and dancing.	Vocal improvisations (therapist)	Legitimizing the client's emotions and aspects of her personality. (Cooperates fully)	Trumpet	Vocal image (legitimization)
28	19-21	Voices of self (good vs. bad)	We explore the voices Noa attributes to the perceived negative side of herself as well as the voices of the	Exploration of different voices	Work on self image through perceived split in self-	(Audio recording)	Vocal image

			parts she views as positive. She moves back and forth between the voices of these two sides of herself she views as opposing through play, speaking as them and improvising songs they may sing.	(speech, vocal improvisation)	perception, thriving toward an integrated concept of self she could accept.	Accompanying instruments	
29	21-23	Character voices	Noa puts on musical plays in which we take turns playing an evil monster with accompanying scary monster voices. The monster now always ends up befriending and even protecting the good, sweet princess with the delicate voice.	Character voices: Exploration of different voices within self (scary/evil monster voice, sweet/good princess voice)	Work on spit in self-perception through concepts of good and evil with accompanying voices. (Continued motif of evil becoming good, but more rejecting toward storylines in which good and evil can co-exist with the same entity).	Monster mask	Vocal image
30	22-24	Songs of self	Inspired by existing songs on the topic, Noa improvises songs regarding self-image which include opposing aspects within herself, some of them negative.	Vocal improvisation on familiar tune (client)	Working toward a more integrated self-perception. (Noa requests to take home recordings of these songs and presents them to her parents with pride. She requires much reassurance she is still accepted and loved as she is with	(Audio recording) Pre-composed songs, microphone	Vocal image

					all these different aspects of herself).		
31	25	All voices in one	I sing goodbye to all the different parts of Noa. She joins in suggesting these, while playfully acting them out with appropriate facial expressions, body language and vocalizations. Among those she suggests: Loving, angry, sweet, mischievous, annoying, goodhearted and "monster" Noa.	Vocalizations of different voices (client), speech, vocal improvisation of song (therapist)	Summarizing, legitimizing and helping her to embody and accept the varying aspects of herself as she is today. (Requires reassurance she is still loved).	Accompanying instrument	Vocal image

Case Study 3

Int. no.	**Session**	**Name of intervention**	**Description of intervention**	**Vocal technique**	**Insights/ effectiveness/rationale**	**Materials**	**Comments/ category**
1	1-3 (+ repeated at beginning of several sessions)	Speaking through instruments	Musical conversations on percussion instruments, leading to wind instruments and kazoo	Instrumental "conversations"	Mutual conversations on instruments lead to conversations on wind instruments and later vocal cords. Leads to speaking and singing through kazoo and first word.	Instruments	Pre-vocal, vocal togetherness
2	3	Wind instrument dynamics	Choosing larger wind instruments, playing loudly on them, recording and playing back	Wind instrument use	Playing with presence and being "vocal", enjoying and accepting being loud and heard. Leads to increasing volumes on wind instruments and increased vocality (speech) in room. Correlation between usage of wind instruments (closest to voice) and readiness to use vocality	(Audio recording) wind instruments	Pre-vocal
3	3	Emotion dradel (kazoo)	Playing sounds that express various emotions on kazoo according to emotion shown on "emotion dradel"	Kazoo use (to mask vocality)	Leads to additional freeing up and touching on emotions later	Dradel, kazoo	Pre-vocal, Vocal liberation, vocal

							emotional expression
4	4	Singing in microphone	Sings some words of simple children's song in microphone in imitation of original	Singing	Microphone encourages vocality, familiarity and simplicity of song boosts confidence to sing. Vocal release is increased through singing	(Audio recording)	Vocal liberation (prompting)
5	4,5	Giving sound to fears	Choosing wind instruments with "scary" sounds and using them to represent and banish frightening animals in play	Wind instrument use	Empowerment, confronting fears and emotional release through wind instruments. A step towards vocally expressing fears	(Audio recording) wind instruments	Pre-vocal (confronting fears, empowerment)
6	4, 5	Vocal exploration with microphone	Spontaneously improvising various breath sounds amplified through microphone: heavy breathing, wind, rain…	Free breath improvisation, Natural sounds	Beginning to experience her voice as an instrument she has control over and can take pleasure in and explore without fear, experiencing breath amplified	(Audio recording)	Pre-vocal, Breath exploration (control, sounding)
7	5, 6	Animal sounds	Our lion puppets interact with each other in play through varying dynamics of roars	Animal sound vocal improvisation	Releasing powerful vocal sounds, vocal confrontation through play. Afterwards begins making animal sounds in kindergarten	(Audio recording) puppets	Vocal togetherness, vocal empowerment
8	6	Nonsense song (simple version)	We sing a simple nonsense song together in which she repeats my nonsense syllables and vocal sounds first through kazoo, afterwards adding voice	Sound and syllable imitation through song, kazoo, gibberish	Playing with sounds and syllables. Degree of comfort with voice varies, agrees to recording song while on kazoo instead of singing	(Audio recording) kazoo	Pre-vocal, Vocal liberation (imitation) , vocal togetherness

			(but freezes when I try to record her)				
9	7	Free microphone use: Scary voices	Improvising "scary" vocalizations in microphone (animal and indescribable guttural sounds…)	Vocal improvisation on emotion, animal sounds, natural sounds	Recording led to drawing "scary picture" of various things feared (bats, fire, a storm, a man) and continued work on fears	(Audio recording) drawing	Vocal emotional expression (fears)
10	8	Banishing fears with voice	Banishing fears represented by loud instruments with cymbals combined with yelling "go away!"	Speech	Continued work on fears	Instruments	Vocal confrontation of fears, vocal empowerment
11	8, 30	Vocal unfreezing	"Freezing" in place while prancing around the room when she hears an instrument associated with a fear, and releasing herself from being "frozen" by throwing a beater on the large cymbal while shouting "eeya!"	Vocal play (+ movement), natural sound	Practicing release of physical and vocal tension	Instruments, movement	Vocal liberation
12	9	The vocal shield	While dancing an improvised "shield dance" to music in the dark while holding a "shield" she made, whenever an instrument representing a fear is sounded, she yells at it "leave me alone!" while holding up her shield to whichever	Speech	Added movement to increase sense of empowerment and physical release of freezing	Handmade shield, instruments, movement	Vocal empowerment, vocal confrontation of fears

			direction the sound is coming from				
13	12	Animal wars	Two instruments shaped as animals "fight" with Boomwhackers used as swords with added animal vocal sounds	Animal vocal sounds (confrontational)	Leads to loud playing and vocalizations and playful confrontation	boomwhackers	Vocal empowerment, vocal confrontation of fears
14	13	Vocal imitations	While playing darbukas she is instructed to imitate my playing and afterwards when I add vocalizations to my play which vary in dynamics she imitates those as well	Imitation of vocalization and dynamics	Variation and experimentation of vocal dynamics (will not initiate vocalizations in this intervention until session #25, when she initiates gibberish)	Darbukas	Vocal modification (dynamics)
15	13	Throwing the voice	While throwing a ball between us we also "throw" a word that must reach the other. We gradually take steps backward away from each other as the game progresses, requiring a raising of the voice	Imitation of vocalizations and words, dynamic play	Experimentation and control of vocal dynamics	Ball, movement	Vocal modification (dynamics)
16	14-16	"I don't know" kazoo game	Kazoo conversation during which we each take turns asking each other gibberish "questions" we can't understand and respond in speech through the kazoo "I don't know"	Conversing on kazoo (gibberish and "speech")	Legitimizing not always knowing and encouraging its expression instead of freezing or becoming silent (led to an outburst of uncontrollable laughter). Following session answers a question with "I don't know" instead of silence.	Kazoo	Vocal liberation (encouraging speech)

17	14	The scarf game	While throwing a scarf between us she must throw it back as quickly as possible, first with an imitation of a vocal sound and words and later while continuing the singing of familiar songs I initiate. A second scarf is added later, increasing the speed of response	Imitation of vocalizations and words, song continuation	Used to encourage spontaneous speech instead of usual hesitations. Led to playful behavior in same session	Scarves	Vocal liberation (spontaneity)
18	14-17	Crescendo game	Drumming a progressive crescendo (pp-ff) and adding a vocal crescendo to it of an empowering sentence chanted (later full songs)	Chanting on dynamics	Practicing and legitimization of raising the voice	Audio recordings, drums	Vocal modification (dynamics), vocal empowerment
19	14	Ambulance	Raising the voice in pitch while imitating an ambulance according to the height she throws a small ball. The higher she throws it the higher the pitch of her voice accompanying it.	Vocalizing on pitch	Encouraging freer and more expressive use of the voice (rather than monotonic)	Ball	Vocal modification (pitch), Vocal liberation
20	14	High-low singing	Singing familiar songs while focusing on different parts in her body (top of head, chest, stomach, feet…)	Pitch variation singing	Encouraging freer and more expressive use of voice, vocal control	Audio recording	Vocal modification (pitch), Vocal liberation
21	15	Emotion improvisation	Choosing an emotion ("happy") and improvising	Vocal improvisation on	Encourages vocal and verbal expression of emotion	Piano	Vocal togetherness,

			on it together on the piano, later adding to the playing a joint vocal improvisation on the word and emotion "happy"	word and emotion (mutual)			vocal emotional expression (happiness)
22	17	Q&A spontaneity game	Throwing a ball to her with questions escalating in complexity (from yes/no questions to more open-ended ones) which she throws back as quickly as possible with an answer or a response of "I don't know".	Q&A speech	Encourages spontaneity in responding to questions instead of freezing response	Ball	Vocal liberation (spontaneous verbal response)
23	17,(31, 37-variation other fears)	"I'm not afraid" song	Confronting characters from her previous "scary picture" through a song I improvise for her accompanied by the guitar, while joining in on the chorus with a darbuka, yelling "I'm not afraid"!	Singing predetermined sentence in song, shouting	Confrontation of fears through augmented vocality. Leads to her talking about which fears are no longer relevant and crossing them off her picture, and what still frightens her and why	(Audio recording) darbuka, drawing	Vocal confrontation of fears, vocal empowerment
24	18	Scaring the fears away	Sitting behind a drum set, whenever I introduce a puppet she deems frightening (such a lion, snake, witch, dinosaur…), she scares it away by drumming loudly while yelling at it "you don't scare me!"	Shouting	Confrontation of fears through augmented vocality.	Puppets, drum set	Vocal confrontation of fears, vocal empowerment

25	19	"Happy song" turn-taking vocal improvisation	We improvise a song on things that make her happy, while passing the microphone between us. The result is she imitates my vocality exactly.	Vocal imitation of melody and emotion in improvised song	Encouraging vocal expression of emotion	(Audio recording)	Vocal emotional expression (happiness), vocal togetherness (modeling, legitimization)
26	20	Emotional song singing	We sing together the "goodbye song" according to varied emotions	Singing together (familiar song)	Encouraging vocal expression of various emotions. (Performed with loud and dramatic voice)	(Audio recording)	Vocal emotional expression (varied), vocal togetherness (modeling, legitimization)
27	21-22	"Don't want to!" song	We improvise a song together in which she must answer loudly "I don't want to!" (while hitting the darbuka) to things mentioned in the song that she doesn't want to do. (Later expanded to include things she does want)	Improvised song with roles, speech	Encouraging and legitimizing assertiveness and expression of needs	(Audio recording) darbuka	Vocal empowerment (assertiveness), vocal togetherness (modeling, legitimization
28	22, 23, 29	Gaze song-conducting game	She "conducts" my singing of songs with her gaze (through lifting/lowering of gaze, blinking, etc.)	Singing (therapist)	Encouraging eye contact	___	Voicework on non-vocal issues
29	23, 26, 28	Territory drum games	We divide the drum set between us and begin playing, each on their assigned drums. Whenever	Vocal augmentation and assertion through play	Encouraging and legitimizing assertiveness (becomes increasingly more playful and	Drum set	Vocal empowerment (assertiveness)

			I play on hers, she must banish me with her drum sticks and yell "no!" or "stop it!" I do the same when she "invades" my territory.		courageous in responses during intervention)		
30	24	Mutual Q&A song	We improvise a song throughout which we take turns asking and answering each other's simple questions	Improvised mutual conversational song	Encouraging and practicing initiating (and responding to) questions. (Answers shortly but freely, tends to imitate my questions and not think up new ones alone)	Accompanying instrument	Vocal liberation (conversational)
31	24, 30	Gibberish conversations	After conversing on the kazoo we begin conversing through gibberish, mutually asking and answering questions, adding various emotions	Gibberish (Q&A), kazoo	Encouraging and practicing initiating (and answering) questions. (Initiates questions on her own, doesn't imitate, free flowing conversation, very expressive and playful)	(Audio recording) kazoo	Vocal liberation (conversational), vocal emotional expression
32	24-25	Gibberish song	We improvise a song in gibberish together while passing the microphone between us	Gibberish free improvisation (mutual)	Encouraging spontaneous vocal interaction and contribution	(Audio recording)	Vocal liberation (interaction)
33	24	Answering with instruments	She chooses a different instrument for 3 possible answers (yes, no, I don't know) and must respond to my questions with the appropriate answer while playing the instrument she chose for that response	Speech (responses)	Encouraging free-flowing answering (as opposed to hesitant). (Responds immediately)	Instruments	Vocal liberation (spontaneous response)

34	25, 26	Wrong answer game (with instruments)	Same as above, but must give "wrong answer" on "wrong" instrument to my questions. Afterwards we switch roles as she asks me questions and I give a wrong answer. (Game repeated in later session with variation)	Speech (asks and answers)	Working playfully on fear of making mistakes when answering questions, encouraging initiating questions (her questions are now only partially imitations, though no eye contact is made when initiating)	Instruments	Vocal confrontation of fears, vocal liberation (initiation)
35	26, 27	Queen of the jungle	As "queen of the jungle" (wearing costume and crown), she must ascertain her position by defeating her competitors (played by me with puppets) in a "roar-off" during which she must roar louder than them and later frighten them with her loud voice	Animal sounds	Encouraging vocal augmentation, confrontation and assertiveness (roars very loudly every time, playful)	Puppets	Vocal empowerment (assertiveness), vocal confrontation of fears
36	27	Vocal role play	We role play a conversation between her and her new teacher based on her drawing of her speaking to her 1st grade teacher	Speech	Practicing unfreezing her voice when attempting to speak to her new teacher	Drawing	Vocal liberation (conversational)
37	28, 29	Q&A song	Participates in a song in which she must shortly answer my questions and repeat them back to me	Singsong speech (Semi-structured song & imitation)	Encouraging and practicing initiating questions (avoids eye contact during song and speaks quietly)	____	Vocal liberation (conversational)
38	28	The roaring game	Following her claim that she fears people may "roar" at her if she speaks	Animal sounds	Confronting fears and empowerment. (Leads to her revealing her fears of being	Puppets	Vocal confrontation

			with them, we play a game in which animal puppets roar at her and she must roar back at them		yelled at and hit and recalling incidences in which she actually received such responses)		of fears, vocal empowerment
39	28	Fighting back	While hitting a punching bag she yells "stop it!" "go away!"	Yelling	Empowering her and helping her feel capable of defending herself and not freezing in feared situations (responds with loud yells, smiles and laughter)	Punching bag	Vocal empowerment (assertiveness), vocal confrontation of fears
40	29	Vocal self defense	She chooses instruments for herself (egg shakers) and for her aggressors (cymbals) based on a drawing she drew of a "bad memory" she had of being beaten by a group of boys in kindergarten. Afterwards, she chooses which instrument could help her stand up to them (drum set) and chases her aggressors away while drumming and yelling at them to stop and leave her alone	Yelling (initiated)	Empowering her and helping her feel capable of defending herself in feared situations and being able to rely on her voice when she needs it (initiates the yelling and specific words used)	Instruments, drawing	Vocal empowerment (assertiveness), vocal confrontation of fears
41	30, 31, 36	Vocal dynamics game	When I ask her a question in whispering voice she must answer in a loud one, when I ask her in a loud voice she must respond in	Speech (dynamics)	Encouraging non-threatening use of her loud voice and responding even to loud voices she perceived as frightening	(Audio recording) Darbuka	Vocal modification (dynamics), vocal confrontation of fears, vocal

			a whisper (accompanying her voice on a darbuka)				liberation (conversational)
42	31	Microphone games	While singing a simple song in the microphone she is given control over the volume options and may make her voice sound louder or quieter (also during playback of recording)	Singing (dynamics)	Becoming accustomed to hearing herself using a loud voice (she mostly raises the volume to fairly loud levels)	(Audio recording) Microphone, recording	Vocal modification (dynamics), vocal image
43	32	Classroom simulations	We simulate classroom situations with puppets, and her puppet (which she gave her name) answers the teacher's questions in class and volunteers for assignments	Speech	Non-threatening simulation of classroom situations perceived as frightening (at first hesitates to actively participate in play, but later begins to loosen up and initiates volunteering)	Puppets	Vocal confrontation of fears
44	33, 58	Musical storytelling	I begin singing an improvised story (accompanied on the guitar) and she fills in the blanks throughout the story.	Speech (filling in blanks), improvised storytelling	Inducing spontaneous speech and touching upon emotional issues (she turns it into a story of a sad girl who can't speak but wants to and ends up not being able to stop speaking)	(Audio recording) Accompanying instrument	Vocal emotional expression, vocal liberation (spontaneity)
45	38, 39	Sighing snakes	Releasing the voice through sighing, increasingly deepening the breath and amplifying and extending the sigh while measuring it's duration by	Sighing and deep breathing	Technique to release vocal tension encouraged through play (cooperates initially but suddenly freezes up when begins to progress in session 38, but not in 39)	Whiteboard	Breath exploration, Vocal liberation (tension release)

			drawing lines ("snakes") on the whiteboard				
46	38	Voice in box	I give her a small box and explain to her it represents her voice box. In it are multi-colored scarves. Together we fling each scarf from the box in the air, each time with an extended sigh while dancing around the room to music. Afterwards, we repeat with "ahh" after assigning a different voice to each scarf according to its color: dark= loud voice, light= quiet voice, etc.	Sighing and deep breathing, vocalizations (varied)	Releasing vocal tension and practicing releasing the voice (fully cooperates, her breathing deepens throughout and her vocalizations become louder and more controlled)	Scarves, small cardboard box, background music	Breath exploration, Vocal liberation (tension release), Vocal modification (dynamics, pitch)
47	39-40	Deep breathing exercises	I help her practice deep breathing, gradually deepening the breath in her body while singing	Deep breathing, singing pre-composed song	Practicing deep breathing to calm herself, release vocal tension and gain a sense of control over her voice	___	Breath exploration, Vocal liberation (tension release)
48	39-40	The balloon game	She tries to blow up a balloon in as few breaths a s she can (until she reaches	Deep breathing and sounds	Practicing breath control (laughs a lot throughout and	Balloon	Breath exploration, vocal

			1), and then as she lets the air out of the balloon (either slowly or instantaneously) she accompanies it with corresponding vocal sounds		later initiates a demonstration for her mother)		liberation (release)
49	39	Volume challenge	She records herself singing a simple holiday song and when played back to her she is encouraged to try to sing louder than her initial recording	Singing pre-composed songs (vocal ingredients)	Practicing and encouraging augmentation of voice	(Audio recording) microphone	Vocal modification (dynamics), vocal empowerment
50	40	Blowing bubbles	She must blow as many soap bubbles as possible with only 1 long breath at a time. Afterwards she crushes the bubbles I blow with cymbals while yelling "Ah!" and then while loudly counting the bubbles she manages to crush	Breath control, natural sounds	Practicing breath control and vocal augmentation (full cooperation, much laughter)	Soap bubbles, cymbals	Breath exploration (deepening and control), vocal empowerment
51	40	Emotion dradel (singing)	Sings a song of choice in different emotions according to emotion shown on "emotion dradel", adding corresponding facial expressions	Singing pre-composed songs	Encouraging expression of emotions vocally, especially fear and anger (sings emotions dramatically)	(Audio recording) Dradel	Vocal emotional expression
52	40	Open wide	I join in her singing with a foam puppet whose mouth	Singing pre-composed songs	Practicing opening mouth to allow voice to emerge more	Puppet	Vocal liberation

			I can control. While singing she imitates the puppet's mouth opening allowing her to open wide enough to allow her voice to fully emerge		fully, clearly and loudly after observing her tendency to barely open her mouth when speaking		(release of technical blockages)
53	41	Blow out the candle	She takes a deep breath and releases it strongly as she tries to blow out a candle in one breath. I gradually distance the candle from her after each successful attempt.	Breath control	Deep breathing and breath control for self-calming purposes and control over vocality (succeeds throughout when not laughing)	Candle	Breath exploration (deep breathing and control)
54	41	Emotional voices	We throw a scarf between us as we take turns vocalizing on emotions on cards we turn over.	Natural sounds, vocalizations, speech -words and sentences (turn taking)	Promoting expression of emotion through voice (spontaneous sounds associated with each emotion quickly develop into words and meaningful sentences and even actual conversation among us on certain emotions as the vocal interaction develops)	(Audio recording) scarf, cards	Vocal emotional expression
55	42, 43, 47	The chatter game	We began with a "chatty" conversation between our xylophones as opposed to a "shy" conversation and then added gibberish chatter after I requested to speak with her "chatty" side. Gibberish turned into	Gibberish, spontaneous spoken sentences	Promoting free and spontaneous vocal expression that need not be "correct", giving voice to a different aspect of her personality (her vocal contributions are especially creative and playful)	Xylophone	Vocal liberation (spontaneity), vocal image

			nonsense words and sentences and later into nonsense storytelling as our interaction progressed. This developed into inviting "friends" (puppets) to join in the conversation and evolved into a play she initiated on overcoming fears.				
56	42	Singing characters	We staged a "singing competition" among different puppets (witch, lion, clown, policeman, monster, grandmother) in which she sang in the microphone as each character in a voice that suited it in particular	Singing pre-composed songs (different voices)	Exploring different and varied voices (sings very expressively as each character)	(Audio recording) Puppets, microphone	Vocal liberation (diversity), vocal image
57	43	Shyness vs. talkativeness	After speaking of her different sides: shy/ talkative, she draws a picture depicting each. In the "shy" picture 3 girls stand each holding a ball in one hand (ball="the house of quiet where one is forbidden to speak"). Each girl says "shhhh…". In the "talkative" picture she draws 3 larger girls each saying "pa pa pa	Vocal games (Improvising on fixed vocal sounds, shouting)	Encouraging and strengthening the "talkative" side of her personality. (Following, she sings the goodbye song herself while accompanying herself on the therapist's guitar for the very first time)	(Audio recording) 2 personal drawings, microphone	Vocal confrontation of fear, vocal empowerment, vocal image

			pa…". She chooses to take the part of "talkative" for herself in a vocal game we play in which I play the "shy" part that tries to silence her with an ongoing "shhhh" sound, and she responds as the "talkative" part with "pa pa pa". As the play progressed, she responded with louder sounds, even yelling and saying she refuses to listen to the shy voice. She eventually throws the "shy" drawing on the floor, away from her, saying (on her own initiative): "I don't want to be shy! I want to be talkative!" She later explains she doesn't like being shy and feels it isn't good for her.				
58	44	Musical questions	I start to add to beginning of sessions an improvised song in which I ask questions surrounding a variety of emotions: "What happened that was happy/sad/scary/annoying …since we last met". I	Improvised singing (therapist), speech (client)	Encouraging the expression of difficult emotions and legitimizing them, continued work on responding spontaneously to questions.	Guitar (accompanying instrument)	Emotional vocal expression (verbal), vocal liberation (spontaneity)

			incorporate her answers to these questions into the continuation of the song, while reflecting them to her and legitimizing them.				
59	44	Nonsense song (advanced version) + battle against shyness	I engage her in a "nonsense song" in which she imitates my "talkative" vocality and sentences pertaining to banishing shyness. She's cooperative while imitating but freezes when given an opportunity to lead in the song. We use her response as an opportunity to "battle" against her shyness. Whenever she freezes, I show her "shyness" drawing (session 43). She responds by hitting it and throwing it to the floor. Afterwards she succeeds in contributing to the song more freely.	Singing (imitation), gibberish, speech	Strengthening the "talkative" side of her personality, overcoming freezing response.	(Audio recording), guitar, drawing	Vocal confrontation of fear, vocal liberation (inhibition release)
60	44-46	Songwriting (mutual): "Come talkativeness"	We write a song together in which she fills in blanks and composes the chorus of the song alone. She later chooses instruments to accompany the 2 sentences of the chorus: for "go	Singing/songwriting (personal song)	Affirming her progress so far and encouraging continued development, promoting vocal expression of personal situation (she is particularly satisfied with the version she sings by herself. Requests to	(Audio recording) personal song, instruments, pantomime	Vocal emotional expression, vocal image

			away shyness" she chooses the cymbals and for "come talkativeness" she chooses wind chimes. We perform 2 separate expressive versions of the song: 1- We each sing the part of the song we contributed 2- She sings the entire song herself while I accompany on guitar. While listening to the recordings, I encourage her to perform pantomime to the song and she does.		copy the recording to a CD to take home and designs the CD's cover with drawings of people talking to each other)		
61	47	Vocal graph	We improvise vocally together according to graphs we draw on the whiteboard, from beginning to end and from end to beginning. We sing the graphs and create graphs to improvised vocalizations.	Vocal play vocalizations (vocal improvisations structured by graphs)	Promoting more uninhibited use of voice (she cooperates only when we sing together. When she does improvise her voice is mostly monotonic and the ups and downs of the graph are downplayed vocally)	Whiteboard	Vocal liberation (vocal diversity), vocal modification (pitch)
62	47	Rapping the shyness away	We improvise a rap song together to background beats that she directs toward her "shyness". Throughout the song she shouts: "Go away!", "leave me alone!", "stop it!"….	Improvised rap (shouting)	Confrontation of shyness (freezes initially but loosens up after she begins banishing the shyness)	(Audio recording) microphone, background beats	Vocal confrontation of fear, vocal emotional expression, vocal empowerment

63	49	Vocal masks	She chooses among an array of masks and sings a song in a voice that suits the mask chosen. I later turn this into a game by guessing which mask she chose according to the singing voice she uses.	Singing pre-composed songs (different voices)	Exploring different and varied voices (her vocal variations include mostly low, scary, high pitched and angry voices. Participates fully but initially balks when come upon a mask she "doesn't know" how to sing for. She eventually makes an attempt after we discuss the difficulty.)	(Audio recording) Masks	Vocal liberation (diversity), vocal image
64	50	Playing with pitch	We throw a ball up in the air to varying heights and accompany it with our voice, varying our pitch accordingly.	Vocal improvisation (ingredients: pitch)	Freeing the voice from pitch restraints (after initial difficulty in making a vocal sound, cooperates and enjoys)	ball	Vocal liberation (diversity), vocal modification (pitch)
65	50	Vocal ball games	We play a series of vocal games escalating in difficulty, while rolling a ball between us. Whoever has the ball must roll it back immediately (as if it's a "hot potato") with a 1) vocal sound 2) With the continuation of a known song 3) with the continuation of an improvised melody	Natural sounds, singing pre-composed songs, vocal improvisation	Practicing spontaneous and free use of voice	ball	Vocal liberation (spontaneity, inhibition release)
66	50	The voices within	She chooses the voices she believes are within her from expression cards	Speech (different voices)	Accessing her various voices and "authentic" voice for full self-expression	Expression cards	Vocal emotional expression

			portraying faces with different emotions. The voices she chooses as hers are: happy, excited, sad, worried. I then sing a Q&A song to her and she answers each question in all the voices she chose as possessing.				(varied), vocal image, vocal liberation (diversity)
67	50	The angry voice	She chooses the voice she doesn't think she possesses from expression cards. She claims: "I'm never angry!" A discussion follows on when she might want to use an angry voice and what she may achieve though it. She decides to use an "angry" voice to deal with her "shyness", so it may "understand she's serious" about it leaving and not returning to bother her. We take turns deciding what angry words we could use and add them to a rap rhythm in an "angry" voice.	Speech-rap (emotion)	Vocal expression of repressed/feared emotion (She reveals a fear of other's angry voices)	(Audio recording) Expression cards, rap rhythm, microphone	Vocal confrontation of fear, vocal emotional expression (anger), vocal image
68	51	The scared voice	After she chooses "afraid" as the voice she wants to rid herself of, I improvise a song of things that may	Speech (vocal ingredient: fluctuation)	Vocal expression of fear, catharsis (What frightened her most was: injections,	Shaker	Vocal emotional expression (fear)

			frighten her and she interjects with "that's scary!" while adjusting the volume of her voice and its tremolo according to the intensity of her fear of each thing mentioned in the song. She accompanies herself with a shaker. If something mentioned didn't frighten her at all she responded "that isn't scary!"		getting lost and speaking to strangers)		
69	51	Voices of fear	We improvise together on the piano on the emotion of fear while adding fitting "scared" vocalizations. We do the same for "scary".	Natural sounds (vocal ingredient: fluctuation, loudness, pitch)	Vocal expression of fear, catharsis (Explains she would prefer to be "scary" than "scared" because when you're scary "you're strong")	Piano	Vocal confrontation of fears, vocal emotional expression (fear)
70	52, 54, 55 (variations on intervention)	Box of strengths	She creates a "box of strengths" into which she inserts cards she wrote her strengths and abilities on. She uses this box to battle against instruments and puppets she chooses to represent her "shyness" and fears, throwing cards from the box at them when they approach the "fortress" she hides behind. As she throws	Speech (augmented), shouting	Positive empowerment through personal strengths, improving self-image (laughs and often shouts the words, her vocal volume increasing throughout. Leads to drawing she titles "Leah conquers the shyness")	Handmade "box of strengths", puppets, instruments	Vocal empowerment, vocal confrontation of fears

			cards at them, she reads out loud the strength written on the card, often shouting it at them.				
71	57	Laughter dialogue	We carry on a conversation through laughter alone	Natural sounds (laughter)	Vocal release, vocal expression of positive emotions	____	Vocal liberation (tension release, inhibition release), vocal emotional expression (happiness)
72	58	Finding middle ground	We begin by dividing a large bass xylophone between us. We take turns playing either the role of "shyness" or "talkativeness", while the other plays the opposing role. We add appropriate vocalizations to each role as each try to interrupt and disturb the other's playing and vocalizations (symbolized in instrument playing by playing on the other's side of the xylophone). Afterwards I suggested we search for "the middle" between shyness and talkativeness.	Vocalizations (syllables, words, vocal dynamics)	Working on finding middle ground between her extremes of either not speaking or interfering in class (when it came time to interrupt each other she initially hesitated, but afterwards loosened up and began to laugh. She later claimed she preferred "the middle", claiming she could "be with friends better" that way.)	Bass xylophone	Vocal modification (degree of vocality)

			This led to playing in the middle of the xylophone while accompanying herself with vocalizations that were to neither extreme.				
73	59	Conversational styles	We translate the playing of different conversational styles to actual speech conversations of differing styles (shy, chatty, somewhere in between…)	Speech	Expanding her repertoire of conversational styles and supporting the possibility of finding a middle ground between extremes.	(Audio recording) Instruments	Vocal modification (degree of vocality)
74	61	Singing sad	We sing a song she chooses moving vocally from the emotion of happiness to sadness, with "in between" in the middle.	Singing (song)	Expressing sadness vocally instead of freezing vocally when she experiences that emotion (following such incidences at school)	(Audio recording)	(Unfreezing of the voice) vocal emotional expression
75	63, 64	Hidden/emerging voice	After I present a glove-puppet of a bird's nest out of which baby birds emerge, we use it as a metaphor to her voice. She manipulates the puppet while singing according to hidden vs. emerging voice.	Singing (song)	Controlling and releasing the voice.	(Audio recording) glove-puppet	Vocal liberation
76	63	The strong voice	She sings a set melody on the line "I have a strong voice" on rising scales played on the piano, while progressively singing louder as the scales rise.	Singing (set line/melody, dynamics)	Supporting evolving perception of her voice and self (when her voice hit a dynamic peak she would suddenly fall silent and lower her head).	Piano	Vocal modification (dynamics), vocal empowerment

77	63	Angry duck	Playing a loud duck whistle, she was encouraged to play an angry duck which frightened all the other birds on the glove-puppet into hiding in their nest with its angry, loud voice.	Wind instrument use (whistle)	Touching upon her fear of loud/angry voices (lead to a discussion on whether loud voices are frightening because they sound angry, and if loud voices can also express positive emotions)	Duck whistle, glove-puppet	Vocal emotional expression (anger), Vocal confrontation of fears
78	64	Angry kazoo conversation	We play an angry conversation with each other on kazoos, moving to using actual angry words and sentences said into the kazoos (therefore distorting our voices)	Kazoo, speech through kazoo	Working on fear of angry voices (her own and others') and on vocal confrontation (When we began to actually speak through the kazoo, she would only imitate my questions and would not come up with an answer or question of her own. When suggested she do so she suddenly fell silent and lowered her head).	Kazoos	Vocal togetherness, Vocal emotional expression (anger), Vocal confrontation of fears
79	64	Voice's cave	We played a game with a play tunnel (using it as a "cave") in which during the "day" her voice hid in the "cave", keeping silent, and at "night" (using a flashlight in the room with lights out) it emerged from the cave to play with the other voices: Speaking in gibberish, vocalizing while	Free vocalizations, gibberish	Controlling and releasing the voice. (Afterwards, she told me she enjoyed it when her voice came out to play, and that it was boring when her voice hid throughout our play. She told of her enjoyment of speaking with others. When I asked what could make her voice go into hiding, she responded "being	Play tunnel, flashlight, scarves	Vocal liberation

			dancing around the room with scarves….		scared like when someone makes a loud voice")		
80	65	Unwanted guests	Different characters (portrayed by dolls) try to invade her cave (play tunnel) and she must banish them with her loud voice. Develops into a volume competition among the voices.	Speech (free, augmented)	Asserting her voice, confronting fears of invasiveness in general and of sounds in particular. (Yells mostly "stop it!", "go away!" very loudly)	Play tunnel, dolls	Vocal modification (dynamics), Vocal confrontation of fears
81	66	Singing an instrument	Playing with a glove puppet of a family, she decides which instrument each family member is frightened of and plays all of them. She then imitates each "scary" instrument with her voice, attempting to scare each puppet back into their house. We end with each puppet "learning" to play the instrument they fear so they will no longer be afraid of its sound.	Instrument imitations	Working on fears of loud sounds and experiencing herself playfully as loud and powerful (her voice becomes progressively louder as she carries on)	Instruments, glove puppet	Vocal confrontation of fears (and controlling), vocal empowerment
82	67	The angry voice	Playing with a glove puppet of a family, she is encouraged to try to find a way to anger each family member. She freely responds by shouting at them loudly, playing	Shouting (natural sounds, spontaneous words)	Accessing her "angry voice", working on fear of yelling/anger (her own and of others, especially of teacher's). (Laughs throughout).	Instruments, glove puppet	Vocal emotional expression (anger), Vocal confrontation of fears

			loudly at them and even by hitting them with a beater. When I add a teacher puppet which tells her to "quiet down and return to her seat", she spontaneously responds with loud drumming while yelling "Stop it! Go away!", and hits the teacher with beaters.				
83	68	Vocal emotion collage	She chooses instruments for the emotions of: Fear, anger, happiness, sadness. When I play on one of the instruments chosen, she must say a fixed sentence in a voice that matches the emotion of the instrument. This develops into an "emotional collage" we record in which we each sound our voices while accompanying the emotion we chose on the instruments, merging our voices and moving through the emotional possibilities.	Scripted sentence (emotions)	Legitimizing the vocal expression of a range of emotions. (Her voice becomes louder as the intervention progresses)	(Audio recording) Instruments	Vocal emotional expression (varied), vocal togetherness
84	69, 70	Roaring people	She draws a "scary picture" to scary music: A caged lion at the zoo	Animal sounds (roars)	Working on fears of angry reactions and their accompanying sounds,	"Scary picture"	Vocal emotional expression

			roaring loudly at a boy. She explains that the lion is angry at the boy because he threw a stone at him. She confirms that people also sometimes roar like the lion when they're angry and that it scares her because it "hurts her ears". We play with different types of roars: Loud scary ones and quieter, mellower ones as we role play different behaviors of the boy in her picture toward the lion and the lion's possible reactions, taking turns as the boy or lion.		understanding that not all angry responses are alike and need to be feared. (In one extreme scenario she teases the "lion", throws sticks and balls at him over and over, hits anyone who tries to interfere and plays wind instruments loudly in their ears and yells loudly at them. At some point claims she wants to "take over the zoo", free the animals and "let them do what they want").		(anger), vocal confrontation of fears
85	71, 72	Singing through the shyness	She chooses a puppet to represent "shyness". While she sings a song of her choice in the microphone the puppet suddenly appears at times and she tries to persist in singing despite its presence.	Singing pre-composed songs	Working on her freezing response to anxiety (At first the presence of the puppet causes her to suddenly stop singing and lower her head. After few attempts she succeeds in continuing to sing despite its appearance and begins hitting the puppet until it disappears again. This leads to additional tasks in which she must conquer her freezing response when the shyness puppet appears. Afterwards	(Audio recording) Microphone, puppet	Vocal liberation (control), Vocal confrontation of fear (difficulty)

					she tells her mother that her shyness won't bother her anymore).		
86	71	The brave improvisation	I suggest we vocally improvise a melody together in the microphone on how she felt throughout the session, from her shy entrance to dealing with her shyness. We pass the microphone between us, beginning with a timid melody and quiet voice and progressing toward a bold, confident voice.	Mutual vocal improvisation (emotions, shouting, some spontaneous words)	Experiencing her voice (and herself) as strong and confident (Full participation. Her voice becomes loud with much "attack", initiates adding and shouting the words: "We are brave!" Enjoys listening to the recording during following session.)	(Audio recording) Microphone	Vocal emotional expression (shyness/confidence), vocal empowerment, vocal image
87	72	Vocal simulations	We simulate through role playing situations in which she may find it difficult to speak, escalating in difficulty from answering a friend's questions to asking a question of an angry teacher. We work on her vocal ingredients throughout.	Speech (vocal ingredients)	Practicing her vocal responses to feared situations while empowering her vocally (Participates without hesitation in each simulation).	_____	Confrontation of fears, vocal modification (dynamics), vocal empowerment
88	75-78	The anger song	She writes a song of all the things that anger her: teachers, children, friends, siblings, parents. She chooses an accompanying rhythm on the synthesizer. We work on performing	Singing (emotion, vocal ingredients)	Following her discussing her fear of other people's anger expressed by the volume of their voice and her fear it may lead to them being violent towards her, we began touching upon her fear of her	(Audio recording) Composed song, synthesizer	Vocal emotional expression (anger), vocal modification (varied), vocal

			the song with the necessary vocal ingredients suitable for the "angry" voice she aims to achieve (loud, with "attack", low pitch) through: singing the song as a lion puppet she chooses, singing each sentence while throwing a beater at the drum set…		own anger. (Most difficulty admitting anger toward parents. When she finishes, requests to record song to disc to take home and play for her parents "so they'll know I'm angry!" Decides to draw angry faces on the cover of her disc.)		confrontation of fear
89	78, 79	Open wide	She sings a song while spinning the "vocal dradel", singing according to its varying outcome while looking in a handheld mirror: Closed mouth, slightly opened mouth, regular opening, exaggerated opening.	Singing (mouth position)	Working on awareness and on releasing her clenched jaw and opening her mouth wider to allow to voice to fully emerge. (She notices how her usual opening is actually quite small. When she does open her mouth more her voice is far louder and uninhibited).	Vocal dradel, mirror	Vocal liberation, vocal modification (emergence of voice, articulation)
90	79	Throwing the voice (2)	She throws balls with all her strength at a distant wall while yelling "Ya!" and afterwards sings a song while imagining still throwing the balls.	Shouting, singing (vocal ingredients)	Working on fear of her loud voice, accessing her loud, assertive voice to help her be heard in class.	(Audio recording) Ball	Vocal liberation, vocal modification (dynamics), vocal image
91	81	The voices within	She writes down the many voices within her: Thick, thin, huge, angry, frightened, beautiful, quiet, loving, etc. and	Singing (different voices)	Awareness of her voice and expanding vocal options (claims she has within her "all the voices" but would like for her "regular" voice to	(Audio recording)	Vocal image

			sings a song moving vocally through the list.		be louder since she feels she's not heard enough. Liked her "huge voice" the most from the recording but claims she's ashamed to let others hear it, but wants to).		
92	82, 83	The huge voice	When singing into a microphone she is encouraged to give voice to her "loud" and "huge" voice while opening her arms to reflect the perceived size of her voice.	Singing (different voices)	Practicing raising her voice and viewing herself as having a loud voice (She enjoys listening to the recordings).	(Audio recording) Microphone, movement	Vocal modification (dynamics), vocal image
93	85-86	Huge voice letter	She writes down what her "huge voice" (in her words) would like to say to a teacher who yells at her, writing a very angry and threatening letter to that teacher. She reads it out loud, competing in volume with the trumpet she chose as representing the teacher, and afterward accompanies herself on the drum set.	Speech (augmented)	Expressing anger, releasing her loud voice (Following her complaints of the constant yelling of one of her teachers. Expresses initial fear that if she reads the letter too loudly her teacher might actually hear her. Her voice comes out louder than usual, but not "huge" as she intended).	(Audio recording) Letter, instruments	Vocal emotional expression (anger), vocal modification (dynamics), vocal confrontation of fears
94	89-90	"I don't want to!" song	After creating a list of things she doesn't want to do (or doesn't want done to her), I create a song out of the list in which I ask her	Speech (scripted, augmented)	Following her difficulty to refuse to comply to suggestions from others, even in therapy (Responds loudly from the beginning, fully	(Audio recording) "I don't want to" list, darbuka	Vocal modification (assertiveness: dynamics, attack), vocal

			if she wants to do various things she listed. She responds with a chorus of: "No, I don't want to!" while accompanying herself on a darbuka and afterwards even without the darbuka. Following this she added the things she does want to do to our song.		cooperates. Initiates more in following session).		emotional expression (resistance)
95	96	Then and now singing	She sings along with one of the first songs she recorded in therapy, trying to "outdo" her previous recording, singing more confidently and louder.	Singing (augmented)	Summarizing vocal progress. (Sings loudly and confidently)	(Audio recording) Previous recording, microphone	Vocal modification (dynamics, confidence), vocal empowerment, vocal image
96	97	Confronting emotions	We simulate different situations in which others' vocal expression of strong emotions (mainly anger and sadness) frightens or saddens her. We take turns playing the roles of expressing and reacting to the emotions displayed.	Natural sounds (crying, yelling), speech	Following her continued difficulty in witnessing others' expressions of strong emotions.	____	Vocal emotional expression (anger, sadness), vocal confrontation of fears (difficulties)
97	97-98	The brave voice	We work on vocalizing and speaking from her chest resonance, accessing it through exercises such as vocalizing while	Vocalizations, speech (vocal ingredient: chest resonance)	Following her expressed goal of being heard better and being brave enough to speak to "everybody". (Enjoys the	_____	Vocal image, vocal modification (pitch,

			pounding on her chest (Tarzan style).		sounds of this newfound vocal quality)		dynamics, conviction)
98	98-101	The emotion shield	We create a cardboard "shield" and write on it words and sentences that help her feel safe when she feels "attacked" by others. At first, she reads the sentences out loud in her "brave voice". She chooses various instruments to represent the things she feels she needs protection from (such as: others' anger, girls who offend her, predatory animals, sirens…). She chooses sentences from the "shield" can help protect her against each threat and yells them at each instrument that "attacks" while protecting herself with the shield.	Speech (scripted), shouting	Following her feeling attacked by others' words and actions. (In following sessions tells me of how she used the "shield" in different situations).	Handmade "shield", instruments	Vocal confrontation of fears, vocal image
99	102-103	The shield song	She writes a song by herself based on the sentences on the shield she created. She vocally improvises a melody to the song and accompanies herself on a xylophone. I join in on a darbuka. She	Vocal improvisation (on song)	Helping her internalize empowering messages that help her deal with fears through song (She writes the entire song herself and quite spontaneously, improvising a melody alone for the first	(Audio recording) Written "Shield Song", instruments, microphone.	Vocal empowerment

			later adds a trumpet to the recording, claiming it's as strong as the shield".		time. Enjoys listening to the recording.)		
100	104	Assertive improvisations	We take a situation she feels she wants to assert herself in, choose appropriate sentences for the situation from the "shield" she previously made and take turns vocally improvising on the sentences while accompanying ourselves on the darbukas, turning it into a "competition" of who can express the words most convincingly. She continues alone at some point on her own initiative with spontaneous vocal improvisations in which she powerfully asserts her needs.	Vocal improvisations (mutual scripted then on her own non-scripted)	Following a situation she mentions in which she feels she's not being heard and needs to assert herself (The improvisations are long and throughout them she often shouts, sounds assertive and even angry)	(Audio recording) Handmade shield, Darbukas, microphone	Vocal empowerment, vocal modification (assertiveness, conviction)
101	106-107	Singing a drawing	After concluding her drawing titled "I can speak with everyone!" (which illustrates all the situations in which she now speaks), she freely improvises a song based on the drawing which portrays the vocal interactions depicted in it.	Vocal improvisation (non-scripted, on drawing, mutual and by herself)	Summarizing vocal progress towards ending of sessions (she ends the song shouting: "I can already speak with everyone!")	(Audio recording) Drawing, microphone	Vocal empowerment, vocal image (vocally summarizing process)

			Afterwards we improvised together on the drawing in a conversational style.				
102	108	Investigating voices	We investigate all the different voices she discovered throughout her therapeutic journey through vocal improvisations by herself and with the therapist.	Vocalizations, animal sounds, sighing, natural sounds, rapping, shouting vocal improvisations, (non-scripted, on theme, different voices, mutual and by herself)	Summarizing all the voices she discovered within her towards ending of sessions (In mutual improvisation freely initiates most voices and sounds and imitates less. Lengthy improvisation of 22 minutes)	(Audio recording)	Vocal image. diversity, vocal modification (vocally summarizing process)
103	109-110	Emotional farewell	She writes a lengthy farewell song by herself. I ask her to write next to each sentence the emotion it conveys. The emotions she writes throughout: Sad, angry, brave, confident, hope, happiness, friendliness. She then performs the song while vocally expressing the different emotions conveyed throughout.	Vocal improvisation (on song, on emotions)	Touching upon and vocally expressing the various emotions present in herself and in the farewell sessions.	(Audio recording) Farewell song, guitar accompaniment	Vocal emotional expression (varied, summarization), vocal image (summarization)

Appendix E

Participant Consent Form

<u>טופס הסכמה מדעת להשתתפות במחקר</u>

אני הח״מ:

שם משפחה:_____ שם פרטי:_____ מס׳ ת.ז. _____

כתובת: _____ מיקוד:_____

א. מצהיר/ה בזה כי אני מסכים/ה להשתתף במחקר כמפורט במסמך זה:

ב. מצביר/ה בזה כי הוסבר לי ע״י:

שם החוקרת:_____ כדלהלן:

כי המחקר נערך בנושא: טיפול באמצעות קול לילדים עם פחדים וחרדות: פיתוח מודל קולי למטפלים במוזיקה.

כי אני חופשי/ה להפסיק בכל עת את השתתפותי במחקר.

כי מובטחת סודיות באשר לזהותי האישית וזהות מטופליי במהלך המחקר ובפרסומים מדעיים.

כי בכל בעיה הקשורה למחקר אוכל לפנות לחוקרת להתייעצות נוספת.

ג. הנני מצהיר/ה כי אני נותן/נותנת את הסכמתי לשימוש בדעות אשר אביע, בהקלטות ובחומרים נוספים הקשורים לראיון לצורך המחקר.

ד. הנני מצהיר/ה כי אני מתחייב/ת לשמור על סודיות המידע אשר נמסר לי לצורך השתתפות במחקר ולא להעביר, לשתף או להשמיע את הסרטון שיועבר אליי בחלקו או במלאו לאף גורם.

ה. הנני מצהיר/ה כי נמסר לי מידע מפורט על המחקר ובמיוחד הפרטים הבאים הקשורים: למטרות המחקר, לשיטות, למשך הזמן הצפוי, לסיכונים הטמונים הנפוצים ולאי-נוחות העלולה להיגרם.

ו. הנני מצהיר/ה בזה כי את הסכמתי הנ״ל נתתי מרצוני החופשי וכי הבינותי את כל האמור לעיל.

_____ _____ _____

שם המשתתף/ת חתימה תאריך

ז. הצהרת החוקרת

ההסכמה הנ״ל נתקבלה על ידי וזאת לאחר שהסברתי למשתתף/ת במחקר את כל האמור לעיל ווידאתי שכל הסבריי הובנו על ידו/ידה.

_____ _____ _____

שם הסטודנטית/חוקרת חתימה תאריך

Appendix F

Questionnaire Form

<u>טופס שאלות מקדימות לראיון המטפל/ת</u>

<u>פרטים אישיים ורקע</u>

שם:

מקצוע:

שנות ותק בתחום הטיפול:

לימודים בתחום הטיפול:

לימודים בתחומים נוספים (במידה ויש):

לימודים ו/או התנסות בתחום השירה והקוליות:

אוכלוסיות עמן את/ה עובד/ת או עבדת:

ניסיון בטיפול בילדים הסובלים מפחדים ו/או חרדות:

<u>שאלות</u>

האם את/ה עושה שימוש בקוליות בטיפולים שלך לרוב כמדיום עיקרי או כנלווה למדיום אחר?

באילו אופנים את/ה נוטה לעשות שימוש בקוליות בטיפולים שלך?

באיזו מידה את/ה נוטה לעשות שימוש בקוליות בטיפולים שלך להערכתך (במידה רבה/בינונית/מועטה)?

מה הן העקרונות החשובים ביותר בעינייך בטיפול בילדים?

מה הן העקרונות החשובים ביותר בעינייך בטיפול בילדים עם פחדים וחרדות?

אילו שיטות או גישות קוליות (מאלה הקיימות היום בספרות המקצועית) מצאת כיעילות במיוחד בטיפולך באוכלוסייה זו (בעבר או בהווה)?

Appendix G

Interview Questions

<u>שאלות לראיון</u>

1. מה הן התרשמויותיך מן המודל הקולי?
2. מה הן לדעתך היתרונות של המודל?
3. מה הן לדעתך החסרונות של המודל?
4. לאילו קליינטים המודל עשוי להתאים?
5. לאילו קליינטים המודל עלול שלא להתאים?
6. אילו תכונות ויכולות צריכות להיות למטפל בכדי ליישם את המודל?
7. אילו הכשרה ו/או רקע צריכים להיות למטפל בכדי שיישם את המודל בעבודתו?
8. האם המודל יכול להתאים גם למטפלים במוזיקה בתחילת דרכם?
9. עד כמה המודל מתאים לדעתך לטיפול באוכלוסיית היעד של ילדים עם פחדים וחרדות?
10. האם ישנם אספקטים במודל שהיית משנה?
11. אם כן, מה הם וכיצד היית מציע/ה לשנות אותם?
12. האם ישנם אלמנטים או עקרונות נוספים שלא הוזכרו במודל העשויים לתרום לעבודתך הקולית עם ילדים?
13. מה היה מביא אותך להגברת השימוש בקוליות בטיפולים שלך?
14. מה היה מסייע לך ליישם את המודל הנ״ל בטיפולים שלך?

Appendix H

Participant Consent Form

<u>טופס הסכמה מדעת להשתתפות במחקר</u>

אני הח״מ:

שם משפחה:_____ שם פרטי:_____ מס׳ ת.ז. _____

כתובת: _____ מיקוד:_____

א. מצהיר/ה בזה כי אני מסכים/ה להשתתף במחקר כמפורט במסמך זה:

ב. מצהיר/ה בזה כי הוסבר לי ע״י:

שם החוקרת:_____ כדלהלן:

כי המחקר נערך בנושא: ״טיפול באמצעות קול לילדים עם פחדים וחרדות: פיתוח מודל קולי למטפלים במוזיקה״.

כי אני חופשי/ה להפסיק בכל עת את השתתפותי במחקר.

כי מובטחת סודיות באשר לזהותי האישית וזהות מטופליי במהלך המחקר ובפרסומים מדעיים.

כי בכל בעיה הקשורה למחקר אוכל לפנות לחוקרת להתייעצות נוספת.

ג. הנני מצהיר/ה כי אני נותן/ת את הסכמתי לשימוש בדעות אשר אביע, בהקלטות ובחומרים נוספים הקשורים לראיון לצורך המחקר.

ד. הנני מצהיר/ה כי אני מתחייב/ת לשמור על סודיות המידע אשר נמסר לי לצורך השתתפות במחקר ולא להקליט, לצלם, להעביר, לשתף או להשמיע חומרים מהסדנה בחלקם או במלואם לאף גורם.

ה. הנני מצהיר/ה כי אני מתחייב/ת לשמור על סודיות זהותם של המשתתפים האחרים ועל סודיות המידע אשר נדון במסגרת הדיון הקבוצתי.

ו. הנני מצהיר/ה כי נמסר לי מידע מפורט על המחקר ובמיוחד הפרטים הבאים הקשורים: למטרות המחקר, לשיטות, למשך הזמן הצפוי, לסיכונים הטמונים הנפוצים ולאי-נוחות העלולה להיגרם.

ז. הנני מצהיר/ה בזה כי את הסכמתי הנ״ל נתתי מרצוני החופשי וכי הבינותי את כל האמור לעיל.

_____ _____ _____

שם המשתתף/ת חתימה תאריך

ז. הצהרת החוקרת

ההסכמה הנ״ל נתקבלה על ידי וזאת לאחר שהסברתי למשתתף/ת במחקר את כל האמור לעיל ווידאתי שכל הסבריי הובנו על ידו/ידה.

_____ _____ _____

שם הסטודנטית/חוקרת חתימה תאריך

Appendix I

Questionnaire Form

<u>שאלון מקדים להשתתפות במחקר</u>

<u>פרטים אישיים ורקע</u>

שם:

מגדר: זכר/נקבה

לימודים קודמים (גם שאינם אקדמיים):

לימודים ו/או התנסות בתחום השירה וקוליות (פיתוח קול, מקהלה/להקה, קורסים באלתור בקול....):

אוכלוסיות עמן את/ה עובד/ת או עבדת בעבר בטיפול במוזיקה:

גילאים:

סוגי בעיות:

האם יש לך ניסיון בעבודה עם ילדים בגילאי 3-10 עם פחדים ו/או חרדות?

- אם כן:

  אנא פרט/י אודות ניסיונך עם אוכלוסייה זו:

<u>שאלות נוספות</u>

האם את/ה משלב/ת משחק בטיפולים שלך?

האם את/ה משלב/ת קוליות בטיפולים שלך?

- אם כן:

  באיזו מידה (במידה רבה/בינונית/מועטה)

  באיזה אופן את/ה משלב/ת קוליות בטיפולים שלך?

האם את/ה חש/ה בנוח בשימוש בקוליות בטיפולים שלך?

- אם כן:

באיזה סוגי קוליות את/ה חש/ה בנוח לעשות שימוש (ג'יבריש, שירה, אלתור קולי, ראפ, אפקטים קוליים, דיבור דרמטי, אחר....)?

- אם לא:

  אנא פרט/י את הסיבה או סיבות לכך שאינך חש/ה בנוח בשימוש בקוליות:

מה לדעתך עשויה לתרום לך ההיכרות עם מודל קולי לטיפול בילדים עם פחדים וחרדות?

Appendix J

Focus Group Phase-specific Discussion Protocol

מה הייתה ההתרשמות שלכם מן הפאזה הנוכחית (או מן הפאזות הנוכחיות)?

מה היה יכול לסייע לכם ביישום הפאזה (או הפאזות) בעבודתכם הטיפולית?

ספרו על החוויה שלכם בסימולציה (או בסימולציות).

מה היה יכול לתרום לחוויה שלכם בסימולציה (או בסימולציות)?

Appendix K

Focus Group Concluding Discussion Protocol

כיצד התרשמתם מן המודל הקולי בכלליותו?

מה הם לדעתכם היתרונות של המודל?

מה הם לדעתכם החסרונות של המודל?

האם מתאים לדעתכם להיחשף אל המודל כבר בתור סטודנטים או מטפלים מתחילים?

מה היה יכול לסייע לכם בלימוד המודל?

האם הייתם חשים בנוח ליישם את המודל בעבודתכם (לאחר הכשרה מתאימה)?

מה היה יכול לתרום לכם בבואכם ליישם את המודל?

אילו רקע קולי ו/או הכשרה היה מסייע לכם ביישום המודל הקולי בעבודתכם?

תקציר

מטרת המחקר המוצג כאן לבסס מודל לטיפול באמצעות קול לילדים בעלי צרכים רגשיים אשר סובלים מפחדים וחרדות, בטווח הגילאים 3-10. המודל מיועד לשמש מטפלים במוזיקה כבסיס לטיפול באוכלוסייה זו. פחדים וחרדות הנם תלונות ילדות נפוצות אשר מטפלים במוזיקה נתקלים מולם באופן תדיר בעבודתם הקלינית. התועלת הטיפולית הגלומה בקוליות משמעותית במיוחד עבור קשיים אלו על פי הממצאים המתוארים בספרות המקצועית. יתרה מזאת, הפוטנציאל של הטיפול באמצעות קול באוכלוסייה זו נתפס בעיניי כמבטיח במיוחד, לאור ניסיוני הקליני העשיר והקשר הנצפה בין המצב הרגשי לבין ביטוייו הקוליים.

המחקר פותח בסקירת היתרונות הטיפוליים הטמונים בקוליות והמתועדים בספרות המקצועית מנקודות מבט אבולוציונית, התפתחותית, נוירולוגית, פיזיולוגית, ורגשית. נמצא כי בהתערבויות קוליות טמונות תועלות ואיכויות טיפוליות רבות. בנוסף, הספרות מבססת את הקול ככלי נגינה אישי, מולד, זמין, ומרכזי בהבעת רגש בתקשורת בינאישית. אספקטים אלה תורמים להיותו של הקול מדיום טיפולי רלוונטי לילדים.

למרות תועלות אלו, הספרות העלתה מחסור משמעותי במודלים לטיפול באמצעות קול (voicework models) לילדים. למרבה ההפתעה, לא ניתן היה לאתר בספרות מודל לטיפול באמצעות קול עם ילדים בעלי אינטליגנציה והתפתחות נוירולוגית תקינות, אשר הבעיה העיקרית שלהם היא רגשית. אלה הממצאים על אף שמטפלים רבים במוזיקה עובדים עם ילדים מסוג זה ונוטים לשלב קוליות בעבודתם הקלינית. סקירת הספרות המקצועית לא העלתה אף מודל לטיפול בילדים אלו. המודלים הקיימים הנוגעים לעבודה קולית טיפולית עם ילדים התגלו כמעטים מאוד, בעלי רקע מחקרי דל, והתבססו על טיפול באוכלוסיות בעלות צרכים מיוחדים, מאותגרות קוגניטיבית או התפתחותית. מחקר זה שואף להתחיל למלא חלל זה בספרות המקצועית ולספק מענה לצורך בקהילת המטפלים במוזיקה.

גישת המחקר האיכותני התבססה על המתודולוגיה של מחקר פעולה (action research; AR) ושילבה את הפרדיגמה המסורתית-שמרנית של AR. גישה זו אפשרה את העוסקים בתחום כמו גם אלו בשלבי למידת תחום הטיפול במוזיקה ללמוד, לחוות, ולבצע הערכה של המודל באופן פעיל. בהתאם לגישה המעגלית של AR, המחקר התפתח דרך מעגלים ספיראליים של רפלקציה עצמית הכוללים: איסוף מידע, ניתוח נתונים, הערכת מצב, תכנון לשיפור, וביצוע התערבות. תהליך זה שאף להגדיל את הרלוונטיות והיעילות של המודל. מחקר זה כולל שלושה מעגלים אשר באמצעותם התגבש המודל, התפתח, והותאם לצרכי המטופל ולצרכים המתהווים של המטפל במוזיקה.

מעגל 1 שימש כשלב מקדים של חקירה עצמית דרכו התגבש לראשונה המודל הטיפולי. הוצגו תיאורי מקרה מפורטים אשר התבססו על טיפולים באמצעות קול באורכים שונים באוכלוסיית המחקר. אלה נחקרו לצד תיעודם הקליני, הקלטות אודיו, תוצרי מטופלים, וחומרים רלוונטיים נוספים. הם נותחו באמצעות שיטת ניתוח מסמכים (document analysis). תוך שילוב גישה רפלקסיבית, ממצאי הניתוח אפשרו לי לגבש את העקרונות והאלמנטים לטיפול באמצעות קול עם ילדים הסובלים מפחדים ומחרדות ולבסס את היסודות העיקריים של שיטת עבודה. בכל תיאורי המקרה אשר נחקרו, הפתולוגיה הרגשית של המטופל הגיעה לידי ביטוי ונחשפה באמצעות קולו. התהליך הטיפולי התייחס לביטוי הקולי של הקושי לצד ההיבט הרגשי שלו. בכך הוא התמקד במקביל הן ביעדים קוליים והן ביעדים רגשיים. עניין זה שימש כבסיס למטרת המודל הנועד לטפל במצבים רגשיים וקוליים כאחד, מאחר ואלו הופיעו במקביל והשפיעו זה על זה באוכלוסיית המחקר.

יסודות המודל כללו תשע פאזות קוליות ואחד עשר רכיבים קוליים אשר נמצאו חיוניים לתהליך הטיפול הקולי. פאזות קוליות כללו: עבודה קדם-קולית, יחד קולי, שחרור קולי, הבנייה קולית, הבעה רגשית קולית, העצמה קולית, עימות קולי של פחדים, דימוי עצמי קולי, ועיבוד קולי. פאזות אלה נטו לאפיין שלבים שונים הגלומים בתהליך הטיפול באמצעות קול עם אוכלוסיית המחקר בהתאם למטרותיהן.

בנוסף, נבדק תפקיד השימוש בקול בכל פאזה. בדיקה זו העלתה נטייה כללית של הפאזות המאפיינות את שלבי הטיפול הראשוניים לכלול שימוש רב יותר בקול כגורם טיפולי בפני עצמו (״כטיפול״). פאזות הכוללות שימוש רב יותר בקול לקידום מטרה רגשית (״בטיפול״) נטו לאפיין שלבים מתקדמים יותר בתהליך הטיפול. הדבר הצביע על כך כי בשלב הראשוני של הטיפול השימוש בקול כשלעצמו היה גורם המפתח הטיפולי. על כן, השימוש בקול ״כטיפול״ אפשר למטפל לענות על צרכיהם הראשוניים של מטופלים, לעודד קוליות, ולהניח את התשתית לטיפול ולהגברת השימוש בקול ״בטיפול״.

רכיבים קוליים אשר זוהו כללו: עבודת כלי נשיפה, שירה, חקירת הנשימה, טוניגג, צלילים ראשוניים, קולות בעלי חיים, ג׳יבריש, וורבליות, ווקאליזציה, אימפרוביזציה קולית, וגיוון מרכיבים קוליים. אלה הוגדרו וסווגו על פי מידת המילוליות והאלתור הקולי אשר נדרשו מהמטופל. נמצא כי רכיבים אלה נטו להשפיע על תזמון היישום של הפאזות הקוליות ושל הרכיבים הקוליים לאורך תהליך הטיפול. במטרה לתרום ליישום המעשי שלהם, הוערכה טבלה צולבת בין הפאזות הקוליות לבין הרכיבים הקוליים. טבלה זו הצביעה על תדירות השימוש בכל רכיב קולי לאורך הפאזות השונות. בנוסף, הועלו השערות לגבי קהל המטופלים העשוי להפיק את מירב התועלת משיטת טיפול זו, והוצג דיון העוסק בתפקידו הרב-גוני של המטפל לאורך המודל.

נמצא כי המאפיינים המגדירים את תשתית המודל הנם: מבניות, גמישות, רב-גוניות, ומשחקיות. לאור התפקיד המרכזי של משחקיות בכלל ושל קוליות משחקית בפרט במודל טיפול קולי זה, הוחלט לכנותו "מודל הווקאפליי" (VocaPlay Model).

בהתאם למתודולוגיה של AR, המעגלים הבאים אפשרו את הבחינה של העמדות, ההנחות, המסקנות, ודרך הפעולה שלי בעזרת השתתפותם וסיועם הפעיל של עמיתים למחקר.

מעגל 2 היווה בסיס לייעול, חידוד, בדיקה, ופיתוח מתמשכים של המודל המקורי אשר גובש במעגל 1. במעגל זה, נבחרו להשתתף באמצעות דגימה הומוגנית חמישה עמיתים מנוסים בתחום הטיפול במוזיקה בישראל. מטפלים אלה שילבו קוליות בטיפוליהם והכירו את אוכלוסיית המחקר. הנתונים נאספו באמצעות שאלונים וראיונות פרטניים מובנים למחצה. ראיונות אלה התבססו על הצפייה בסרטון וידאו שהופק באופן בלעדי לצורך מחקר זה. הסרטון סיכם והדגים את עקרונות המודל שגובש במעגל 1. בראיונות נבדקו נקודת מבטם האישיים, התרשמותם, והארותיהם של המשתתפים ביחס למודל שנחקר. החומרים שהתקבלו נותחו באמצעות ניתוח פנומנולוגי פרשני (interpretational phenomenological analysis; IPA).

תמות אשר זוהו באמצעות ניתוח החומרים כללו: שימוש בשיטות קוליות קיימות בטיפול בילדים, עקרונות שנחשבו לחשובים בטיפול באוכלוסיית המחקר, התרשמות מהמודל הנחקר ושיקולים בעניין המטפל שיישם את המודל. תמות רלוונטיות נוספות אשר התגלו כללו: השימוש של המטפל בקולו בטיפול, גורמים המשפיעים על השימוש הפוטנציאלי של המטפל במודל זה בעבודתו, ושילוב של אופני טיפול יצירתיים נוספים במודל.

על סמך ממצאים אלה, הוסקו מסקנות ביחס להתאמת המודל לאוכלוסיית המחקר, התועלת הפוטנציאלית שלו, ויישומיו האפשריים בטיפול. בנוסף, הוערך הרקע הרצוי של המטפל ומאפייניו, לצד גורמים אשר נחשבו כמעכבים את השימוש של המטפל בקולו. הועלה דיון בהצעות לשילוב קוליות בטיפול בצורה מיטיבה ובהנחיות כלליות שנמצאו משמעותיות בעת הצגת מודל הווקאפליי. בהמשך הוצגו נתיבים אפשריים להמשך מחקר, לצד דרכים בהן ניתן להתאים ולפתח את המודל לאור תוצאות מעגל זה. לבסוף, הועלו הצעות לגבור על חסרונות המעגל ולהרחבת תמות להמשך החקירה במעגל 3.

מעגל 3 שילב את המודל הראשוני שנוסח במעגל 1 עם התפיסות וההתאמות שהתפתחו במהלך מעגל 2. במעגל זה השתתפו תשעה סטודנטים הלומדים בשנת לימודיהם השנייה בתוכנית להכשרת מטפלים במוזיקה באוניברסיטת בר-אילן. מעגל זה אפשר את ההתקדמות מתיאוריה למעשה בזכות המדיה האינטראקטיבית של סדנה חווייתית. בסדנה חוו המשתתפים באופן אישי התערבויות טיפוליות מן המודל שפותח עד כה באמצעות סימולציות. משתתפים אלו נבחרו להשתתף באמצעות דגימה הומוגנית. הנתונים נאספו באמצעות שאלונים ראשוניים, הערות תצפית של החוקרת, וקבוצת מיקוד שנערכה לאורך הסדנה.

מעגל זה הוסיף להרחבת ולפיתוח מודל הווקאפליי בכך שהוא אפשר בחינת חוות דעתם של מטפלים הנמצאים בתחילת דרכם בטיפול במוזיקה לצד התנסויותיהם. בנוסף, מעגל זה אפשר בדיקת דעותיהם של המשתתפים בו ביחס ליישומיות המודל.

תמות עיקריות אשר זוהו באמצעות ניתוח החומרים בשיטת IPA כללו: אופן הצגת מודל הווקאפליי, חוויות המשתתפים בסימולציות, רשמים מהמודל המשולב, והשקפות לגבי המטפל שיישם את המודל. על סמך הממצאים שהועלו, הוסקו מסקנות ביחס לשאלות מעגל 2 והוסקו ממצאים לדרך המועילה ביותר להצגת המודל. בנוסף, ניתנה הערכה לתרומת הרכיבים שאינם קוליים וליישומיות המודל. כמו כן, נבחנו היבטים הנוגעים למטפל ולהכשרה הנחוצה ליישום מודל, לצד מידת התאמתה של המודל לאוכלוסיות שונות. לבסוף, הוסקו מסקנות ביחס למידת הרלוונטיות של מודל הווקאפליי למטפלים במוזיקה.

העבודה מסתיימת בפרק סיכום בו מתומצתים ממצאי מפתח הנוגעים ליישום המודל, מובהרים תרומותיו ומגבלותיו של המחקר, ומועלים תחומים אפשריים למחקר עתידי. מודל הטיפול באמצעות קול אשר פותח במחקר זה התגלה כרב-גוני, מקיף, יעיל, שימושי, וישים עבור מטפלים במוזיקה. המודל נמצא כמתאים לילדים הסובלים מפחדים וחרדות, ובנוסף גם כבעל פוטנציאל לטיפול בקשיים רגשיים אצל ילדים באופן כללי.

תוכן עניינים

רשימת טבלאות

רשימת תרשימים

עבודה זו נעשתה בהדרכתו של

פרופ׳ אבי גלבוע

מן המחלקה למוזיקה של אוניברסיטת בר-אילן

טיפול באמצעות קול לילדים עם פחדים וחרדות:

פיתוח מודל למטפלים במוזיקה

חיבור לשם קבלת התואר "דוקטור לפילוסופיה"

מאת:

אליזבט קיי

המחלקה למוזיקה

הוגש לסנט של אוניברסיטת בר-אילן

רמת גן חשוון, תש"פ

טיפול באמצעות קול לילדים עם פחדים וחרדות:

פיתוח מודל למטפלים במוזיקה

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רמת גן חשוון, תש"פ