Music therapy: Performances and narratives

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A common reference to the timelessness of music as therapy is the story of David as he plays the harp for his now dethroned king, Saul. Saul, as you will recall, has had his sovereignty revoked because he failed to do as he was commanded. Kings have instructions and he was told to destroy all that he found before him of the Amalekites. He does but retains their sheep and cattle for himself as plunder. Because he plunders, he is punished. In the story it is said that the spirit of his Lord leaves him and an evil spirit, from the same Lord, possesses him. He is suffering and disgraced. For his relief, David is called for with his harp. He sings for him and Saul’s suffering is relieved – but not cured. The evil spirit leaves him. No, I am not encouraging us to resurrect the idea of evil spirits within mental illness, simply reflecting upon the context in which this use of music as therapy takes place.

First, an acclaimed practitioner practise within a tradition. Remember that it is David who goes on to compose the psalms that are sung, sometimes with instrumental accompaniment. Second, relief is expected. Third, there are a set of mental interpretations for Saul’s difficulty based upon his previous life events (a latter-day psychiatric diagnosis): loss of social status, depressed mood, spiritual possession. This strategy does not always work as we read later, David tries to soothe Saul but receives physical abuse in return when a spear is thrown at him. This is precipitated by Saul’s jealousy but many of us will recognise the situation where one day an approach works but there is no guarantee that the same technique can always be applied. Patients and therapists change in their relationship. Therapy, then, is concerned with the maintenance of a relationship not simply the application of technique.

This then is a characteristic story of affect regulation, interpersonal problems and a disturbed biography. Distress may be localised in one person, but is relational and it occurs over time.

Words or music?

We heard in the example above that David sang to Saul. He didn’t try and counsel him, for that he had his wise men and counsellors. But, there is an important element to music that carries over to speech. If I want to tell you something, then I can give you the information you by telling you the content. This works very well for arranging a meeting, “Eight o’clock, on Friday night, under the bus station clock”. Ah, the memories. But, if I want to tell you something important, like “I miss you”, then it is not only the words that are important, it is the way in which the words are said that convey the intent, as every lover will tell you. With words we can lie, the expression gives the clue to how what is said is to be
It’s not what you say, it’s the way that you say it; and that’s where the music comes into communication.

When we cannot remember by ourselves, then we require assistance. We all have experiences of talking about old times with a friend and how each of us brings varying strands of recollection that weave together the tapestry of memory. To enable us to weave this magic carpet upon which memories ride, music therapists have been honing their varying skills, as we will hear in the following days. These are musical skills, in knowing what music will cue a memory trace, and relationship skills, in knowing how to calm or arouse us such that the conditions for the cue are set. I emphasise both sets of skills here as music therapists use music ‘receptively’, that is, playing chosen music to another person in a therapeutic way and ‘actively’, in that music therapy has a performative component where both therapist and patient make music together. Both forms of activity, receptive listening or making music together, require the essentials of relationship and knowledge.

The subjective “now”

We know from our work with children that music therapy facilitates and enables communication. Indeed, we know that there is an innate musicality to human communication. I have taken this a step further and suggested that the process of living is performative, that we are polyrhythmic, symphonic beings improvised in the moment. This is to emphasise “I perform therefore I am, rather than the Cartesian “I think therefore I am” (Aldridge 1996, 2000a).

What is central to these performances is that they occur now. There is a subjective present that is recognised, and the relationship facilitates the presence of the present. The now of mammalian movement has an estimated duration. Music is the scaffolding of time in which the present is constructed. The construction in time, that we call now, when extended, is the stuff of short-term memory and the basis of cognition. It is also the very ground of feeling. That is how music therapy works, it offers a form for events and feelings that develop an extended “now” into the fabric of memory. Thus musical playing, and communication, is prior to cognition.

A difficulty facing many patients suffering problems with mental health is that their lives are severely restricted. The tragedy is that the sufferers lose the ability to perform their lives both for themselves and with others. They lose their “now” of existence, becoming dislocated in space and disoriented in time. How is it possible to perform a self in these circumstances that is whole? The creative act, in relationship, allows people to perform identities that are not stigmatised where the self can be expressed in the breadth of its capacities. Central to this expression is an awareness of now and the ability to perform in the present. It is music that offers this form for the present as well as calling to the past. The past is called forth into the present and realised anew. These memories too are composed, they may lack accuracy but their potency remains the same. Our biographies have their themes and their feelings and while being mediated by the brain, may originate elsewhere, in our feet, our hands, our hearts.
Music offers us the possibility of composing our biographies anew just as the artist interprets his or her repertoire in a new way. I recently heard Annie Sophie Mutter playing the Beethoven Violin Concerto as part of the WDR series from Cologne. Comparing this performance, to her earlier version that she had performed with Karayan, this version was almost an entirely different piece of music; the tempo was slower, the timbre of her playing had changed – the tones had much more variety. In the Karayan version she was much younger; the tones cleaner, naïve. With her later version, we hear a much more experienced musician bringing a much more mature performance. But both were in differing contexts, differing orchestra and differing conductors.

Prisoners in time, dislocated in space

To act in the world we need the vital coordinates of time and space. We exist in the now and here. While we consider chronological time as important for what we do in terms of co-ordination, it is the idea of time as kairos that is significant. If chronos is time as measured, kairos is time considered as the right or opportune moment. It contains elements of appropriateness and purpose. Inherent within the term is the concepts of decisiveness; there is tension within the moment that calls for a decision. In addition, there is also the expectation that a purpose will be accomplished. While musicians may well play according to a measured time, it is the decisiveness of playing that gives music its rhythm. Rhythm demands intention. Furthermore, the very stuff of improvised playing together is a series of purposive decisions made in the moment that must be acted upon. Kairos reigns where creative purposes are to be achieved.

Patients suffering with problems of mental health become prisoners of mechanical time. They have not a chronic illness but a kairotic illness (Aldridge 1996). The difficulty lies in making appropriate decisions in the moment and acting upon them. Motivation is a problem in that taking an initiative cannot take place; the act cannot be brought into being and therefore purposes remain uncompleted. In this way, mental illness is not simply something that makes no sense; it is something that no longer makes time. While sufferers are “in time”, as chronological events amongst the rest of the world and its myriad of happenings, they are no longer “of time”. This is where our musical understanding of time will bring a significant perspective to bear in the discovery of what it is to be mentally ill. Mentation is a kairotic process not solely understandable in its chronology. De-mentation is the discoupling in kairotic time of physiological, emotional and relational events.

Space, action and gesture

Actions, however, are not restricted to time, they occur in space. We co-ordinate the movement of our limbs to particular places. Movements have an intention that is localised eventually. To dance you have to move your feet in time and know where to put them. The same goes for playing music. We have in some ways become over-balanced in our emphasis on the brain. While it is undeniably necessary, and it is the plaques of Alzheimer’s disease in the brain that are interfering with function, maybe it is in our body where memories are stored. It is our feet that know how to dance, just as our fingers remember how to play and our hearts remember
how to love. If we try thinking about how to ride a bicycle then cognition is of little help. Getting on the bicycle and riding it, the essential bodily activity, is that which achieves the performance. Thus, playing music, dancing, moving, and telling, these activities are prior in the invocation of memory as the calling forth of a performed identity.

The body has perhaps been neglected in communication studies as we emphasise language, yet it is gesture that is pre-verbal and promotes cognition. Posture, movement and prosodics in relationship provide the bases for communication. Through the medium of an active performed body, health is expressed and maintained. Here it is bodily form that guides communication and by which the other may be understood. It has an ambiguous content and it is social. Language provides a specific content and it is cultural. We know that someone is suffering by his or her appearance, what the specific nature of that suffering is they need to tell us. We know someone is happy by what they do, what makes them so happy, they need to tell us. In addition, by moving as if we were happy, we may promote happiness. By moving as if we were sad, we may promote sadness. Thus the body, and a moved body at that, is central to a life amongst others.

A performed identity and a constructed narrative

There is a profound level of understanding that lies beyond, or before, verbal communication. Underlying the concept of a performed identity is the notion that we “do” who we are. We perform our very selves in the world as activities. This is as basic as our physiology and provides the ground of immunology, a performance of the self to maintain its identity. Over and above this, we have the performance of a personality, not separate from the body, for which the body serves as an interface to the social world. We also perform that self amongst other performers; we have a social world in which we “do” our lives with others. This is the social self that is recognised and acknowledged by our friends, lovers and colleagues. This performed identity is not solely dependent upon language but its is composed rather like a piece of jazz. We are improvised each day to meet the contingencies of that day. And improvised with others, who may prove to be the very contingencies that day has to offer!

We perform our identities and they have to have form for communication to occur. Such form is like musical form. Language provides the content for those performances. Thus we need an authored identity to express the distress in a coherent way with others to generate intelligible accounts (Csordas 1983). We have a network of coherent symbols as performed narratives. If language fails then the opportunity for us to accord our form, as selves, with others, appears to fail.

Narratives are constructed and interpreted. They lend meaning to what happens in daily life. We all have our biographies. What happens to our bodies is related to our identities as persons. These narratives are not simply personal stories, but sagas negotiated in the contexts of our intimate relationships. These understandings are also constructed within a cultural context that lend legitimacy to those narratives. Thus meanings are nested within a hierarchy of contexts. The same process applies to the
history of our bodies, to the biography of our selves, to the narratives used by clinicians, or to the tales told by the elders of a tribe (Aldridge 2000a). It may be important to remember here that the word “crisis” has also an element of judgement to it.

The patient and his or her family have a story about the problems that they face. And this story has to be told. It is in the telling that we understand what needs are. It is also in this act of telling that we have the opportunity to express ourselves. The expression of our needs is a performative activity. A patient’s narrative about his illness does not always point out the meaning directly, it demonstrates meaning by recreating pattern in metaphorical shape or form in the telling that is interpreted within relationship. Symptoms in an illness narrative are a symbolic communication as they are told and confessed. Symptoms are signs that have to both observed and interpreted in their performance. We know that many elderly people visit their general practitioner expressing pain and expect a physical examination. Very few say directly that it is painful being lonely and that they are rarely touched. In a culture where it is not allowed to express such emotional needs of suffering and touch directly, then the narrative becomes a medical story of pain. Suffering is embodied as pain. While we may temporarily relieve pain with analgesics, our task is also to understand, and thereby relieve, suffering. In this way the ecology of ideas, that some call knowledge, is explicated within the body as a correspondence between mental representations and the material world. The setting in which we express ourselves will have an influence upon what we express. An extension of this will be that we, as caregivers, are open to the expression of other narratives. Creative arts therapists then will be only too aware of the possibilities of symbolic communication. We are the setting that narratives may be creatively expressed.

Meanings are linked to actions, and those actions have consequences that are performed. What our patients think about the causes of their illnesses will influence what they do in terms of treatment, which in turn will influence what they do in the future. As practitioners, we lend meaning to the events that are related to us by our patients, weaving them into the fabric of our treatment strategies. We must learn to understand each others language for expressing and resolving distress, and act consequently. These expressions are non-verbal and predicated upon bodily expressions that can be seen in movement; or vocal, that are sung; or visual, that are painted. In this way the creative arts offer not only contexts for expression, but also contexts for resolution, congruent to the mode in which the patient chooses to perform him or her self.

For the verbally inarticulate, this has an important ramification as they are offered understanding and the potential for resolution of their distress. For the elderly suffering with dementia, although verbal communication fails, we can offer contexts of expression and understanding where gesture, movement and vocalisation make communicative sense.

For those struggling with verbal articulation, the structuring of narratives offers a meaningful context in which expression can occur. Remembering a story offers an overarching framework that links events together. This is
reflected in the concept of re-collection. We collect the episodes and events of our memories together again.

Health as performance in a praxis aesthetic

Performed health is dependent upon a variety of negotiated meanings, and how those meanings are transcended. As human beings we continue to develop. Body and self are narrative constructions, stories that are related to intimates at chosen moments. Meanings are linked to actions, and those actions have consequences that are performed. The maintenance and promotion of health, or becoming healthy, is an activity. As such it will be expressed bodily, a praxis aesthetic.

The social is incorporated, literally “in the body”, and that incorporation is transcended through changes in consciousness, which become themselves incarnate. Through the body we have articulations of distress and health. While health may be concerned with the relief of distress, and can also be performed for its own sake, sickness is a separate phenomenon. It is possible to have a disease but not be distressed. Indeed, it is possible to be dying and not be distressed. Yet for those who are described as being demented, there is a schism between the social and the body. When communication fails, we literally “fall out” with other people; we fall out of relationship. This is evident in the social difficulties that the demented have; they fail to connect to the rhythms of daily life, to other people and within themselves. We lose our consciousness when connections fail and these are literally organic in the context of dementia and the implications are far-reaching when our body falls out with our “self”. We have lost an inherent ecology.

If we take my earlier metaphor of composition, when bodily function fails, then we are literally de-composed. Yet, as human beings we know that despite our physical failings, something remains within us. There is a self that responds. Despite all that medical science will have to offer us regarding the decomposition of the physical body, it is the composition of the self that we must address in our therapeutic endeavours. It is to the psychological and humanistic sciences that we must direct our attention if we are to gain the knowledge necessary that will aid us in working with those whom come to us for help. Indeed, it is our memories of the other that helps the dementia sufferer compose his or her self. In relationship we foster a return to those ecological connections. And it is music that forms the basis of relationship through rhythm and timbre (Aldridge 1996).

The coherent body and the subjective now

The body becomes an interface for the expression of identity that is personal and social. In a metaphysical tradition, the human being is considered as a self-contained consciousness, homo clausus; yet Smith (Smith 1999) argues for an alternative model, homo aperti, the idea that human beings gain identity through participation in social groups. My argument, so far, is that this identity is performed. Both the personal and the social are necessary. Bodies express themselves at the interface of the personal and the social. Using the body communicates to others.
Using the body achieves perception of the environment, and that includes those with whom we live. But the performance of the body requires a biological system that is intact, a system that remains coherent over time. Memory is the coherence of events in time. When memory fails then a sequence of events lose their coherence. Not only that, if we fail to respond to events that demand a return performance, we are perceived as unresponsive. And the coherence of events is a rudimentary narrative. Our perception of self is dependent upon coherence in time.

I have used earlier the concept of human being as being like a piece of improvised music. For the piece to work as music it has to maintain coherence. We could just as well as taken a raga form where a theme is improvised to its limits, the tension lying in the variation and its relationship to the original theme. To achieve coherence we have to engage in a form that exists in time. A piece of music achieves coherence in its maintenance of form, as does our personal form in social life. If we lose time, then we lose our sense of coherence, and we lose our cognitive abilities too. Just as children gain cognitive abilities with their increasing ability to hold events together coherently in time, then we see the reverse process in the performance of the demented – demented being literally without mental form. This may occur as a performance difficulty through the loss of connections. Within us, there is still a self, with its continuing story that has a developmental need. How is that story then to be expressed? How does the narrative continue such that the saga is told to its end? To do this we need to reconnect. As we see in recovering coma patients, it is the connection of existing capacities in a context of joint attention that leads to an improvement in consciousness (Aldridge, Gustorff, and Hannich 1990). With elderly patients that are demented, therapy must be directed to connecting what intrinsic abilities remain. While these may not be verbal there are other possibilities of sound and movement (Aldridge 2000b).

Narratives and isolation in an ecology of suffering

Our stories are our identities. How we relate them to each other constructively, so that we mutually understand each other, is the basis of communication. What we do, or persuade others to do, as a consequence of those communicated stories is an exercise of power. How narratives are interpreted is important for understanding the ensuing possibilities of treatment. If a person is seen as being illegitimate in her demands for treatment then she may be seen as a social case not needing medical help, and this is critical at a time of stretched medical resources. If a person is seen as being aggressive in his demands by the way in which he expresses himself then he may be sedated rather than change the setting in which he finds himself. This process of problem resolution has consequences for the continuing narration of a patient biography that becomes dislocated from a healthy personal biography. If we become dislocated from our personal biographies then we suffer. Either we are labelled as deviant and become stigmatised, or we become isolated.

In the elderly that become demented, we see people dislocated from their biographies socially, by entering into caring institutions, and personally. Memory fails, and with it self fails to achieve a performance in daily life that integrates
varying faculties. The very “I” that is myself fails to perform the “Me” that we all know. Thus the interface that is self in performance loses its narrative form. Fortunately, the fundamental basis of communication on which that performance is based, our inherent musicality, remains. In the following chapters we will see how skilled practitioners invoke what is still there. The “I” finds its “Me”. All is not lost. There is hope and with that hope then healing.

Health care has ecology. Few of us suffer alone. When we suffer, those whom we love and love us in return are mutually affected. Maybe we can through our endeavours restore those singing duos and bring back those dancing partners together. In a time of managed care, this will be a challenge to creative arts therapists.
