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Research Project:
Enhancing Communication Skills of Girls with Rett Syndrome through Music Therapy

Background:

Girls with Rett syndrome, although quite impaired, show a strong desire to communicate. This is evident by their eye gaze, facial expression and body gestures. They are unable to do so due to the lack of expressive language and the inability to functionally use their hands. Their interest to communicate with others made me pursue their desire through research in music therapy.

Aim:

The aim of this study is to investigate if girls with Rett Syndrome will enhance their communication skills when provided the opportunity to make choices between songs. The research focuses on: 1) intentionality in the girls’ choice making, 2) song preferences, 3) emotional responses to songs, 4) vocalization & 5) body gestures.

Method:
A multiple baseline, single subject design is used in this study. In this time series design, seven girls with Rett syndrome is viewed as a single case unit in which the experimental comparison is within the individual girl. This type of research which has a rigorous methodology, maintains the flexibility in the therapeutic process of the clinical work. Seven girls with Rett syndrome received individual choice making of songs during music therapy. Once the girl made two consecutive choices of the same song, it was sung to her by the music therapist accompanied by the guitar. The research lasted eight months and was videotaped throughout the sessions. Data of the girls' choice making, song preference and other communicative and emotional responses were collected and analyzed by viewing the video materials.

Results to date:

All seven girls show a distinct process in their ability to learn. They show clear intentionality in choosing songs and have preferences between certain songs. Some features such as body rocking and hand wringing vary with the music. Emotional responses and vocalization is being analyzed at this time and seems to be in response to the content of the music. For example, if the music has an element of surprise, most of the girls will respond by laughing, smiling or vocalizing during the exact moment of surprise. Currently I am analyzing qualitatively the music of their most and least favorite songs.

Bibliography related to the research:

Research news is a magazine for sharing research news. This month's practitioner is Hanne Mette Ridder. You can contact her at:

hm@musikterapi.org

research showcase:

Hanne Mette Ridder

Research Project:
Singing in Individual Music Therapy with Elderly Persons suffering from Dementia

Background:

To forget your keys, the name of your neighbour, where you put your glasses, or even forgetting your password, is annoying, - but well, it happens to all of us. But when you forget where you live, fail to recognise a close friend, forget what things around you are called, even your own name, then you have a serious problem!

If a person is confused for more than 6 months, and this is not caused by another illness, if that same person suffers from amnesia and one or more cognitive dysfunctions, then that person is likely to be suffering from dementia. Nearly 100 different diseases can lead to dementia.

Alzheimer's Disease is probably the most well known of the dementias, and together with a type of dementia caused by several small strokes in the brain, it covers most of the dementia cases. To get old does not mean that you forget things and that you cannot perform difficult intellectual tasks! Dementia is a disease and is not caused by age. But the older a person gets, the more the risk of getting a dementia disease increases. In Denmark 2% of the population suffers from dementia, and as the number of old people increases, this percentage is predicted to increase.

In general persons with dementia, among other symptoms, suffer from aphasia and amnesia. This
makes verbal communication very difficult, sometimes confusing and occasionally anxiety provoking.

Singing together seems to be a way of communicating without confronting the various deficits a person constantly faces. As a music therapist, when singing a song with a person, I do not demand things from that person. I do not expect an answer. Singing is a secure way of being together, inviting the person to take part. Constant demands are being made on dementia sufferers throughout the day. When you lose your memory, your history, your identity, your ability to solve problems and answer questions, the reality around you becomes strange and exacting.

In several studies it is documented that singing is a valuable source to increase quality of live with this population. Singing is a viable source of stimulation and interaction, an alternative method of communication, reduces agitation and promotes engagement in an activity, as well as interaction with another human being (for background material see Aldridge, D 2000 "Music therapy and dementia care" Jessica Kingsley Publishers, London http://www.jkp.com/catalogue/mus/ald_mus_dem.html

Clinical Technique:

In the individual music therapy setting singing familiar songs are chosen as a non-verbal form of expression and as a way to

- contain and express inner feelings,
- interact with another person
- stimulate reminiscence and a feeling of identity in a safe and secure relation

In order to create a secure, calm and agreeable situation the structure and the surroundings of the setting is recognizable and familiar. Songs are song acapella in order to relate to a single musical source.

Research Method:

This is an exploratory case study approach. I have made systematic observations of 6 residents, diagnosed with a primary degenerative dementia or a vascular dementia, living in a gerontopsychological unit. Data collection has been based on video recording, heart rate measurements, day-to-day questionnaires, case description and music therapist’s log.

Video recorder was placed in a corner of the room focusing on sofa (or sofa and door in some occasions) where participant and music therapist mostly would be seated, and in this way avoiding having a third person to handle the camera in the room.

Heart rate measurements were done with equipment, which is designed for athletes and allow ambulating.

Staff on day duty, and staff on evening duty filled out day-to-day questionnaires. Questionnaires sought information about daily routines, state of health, and an observation of behaviour (based on
a modification of CMAI: Cohen-Mansfield Agitation Inventory -(Cohen-Mansfield 1996))

In order to describe the participants a MMSE and CMAI was carried out.

(MMSE: Mini-Mental State Examination. Scores in cognitive functioning from 0 - 30. see (Aldridge 1996))

**Procedure:**

Each participant was observed for 6 weeks. In the second to the fourth week participants took part in a daily music therapy session 5 days a week, all together 20 individual music therapy sessions.

The following scheme shows the procedure with each participant:

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**Participants:**

Sex: 2 males and 4 females.
Age. 73-84 years. Average age: 80

Diagnoses: Dementia of Alz’s type (case studies A and B), vasculardementia (case studies C and D),
Dementia vascular/frontal (case study E), and Dementia of Pick’s type (case study F).

Stages of dementia: stages 4-5 (Sandman, PO: stages from 1 to 6)

MMSE scores: 0-5

CMAI: all participants have scores in the groups: physical aggressive and physical non-aggressive. Most have scores in the groups: verbal aggressive and verbal non-aggressive.
Marital status: two participants are married. Four are widows/widowers.

Inclusion criteria:

- diagnosis of primary degenerative dementia or vascular dementia
- no source of cognitive impairment or communication impairment other than dementia
- no history of psychiatric illness or drug/alcohol dependency
- no individual music therapy in last 2½ years
- consent of participant’s relatives
- expression of agitation as defined by Cohen-Mansfield

Hypotheses:

My hypotheses in this research project are:

- that singing has an influence on persons with dementia
- that this influence can be defined upon communicative characteristics
- that persons with dementia in an advanced stage communicate musically, and that this musical communication can be recognised by a system of communicative signs
- that music therapy has an influence on aspects in residential daily life for the person with dementia

Analysis:

I completed data collection end of November 2000 and will now start analysing the material. Parameters describing responses and interaction in the music therapy sessions will be developed based on the video material. Heart rate data and part of the questionnaires will be displayed graphically, and correlation to responses and interaction will be analysed.

This is a research in progress, and some of the data already tells me, that participants profit from the music therapy sessions.

First of all I want to document this through case descriptions supported and documented with different types of data material.

On the video recordings it seems to be clear that 5 out of 6 (5/6) participants shows a direct reaction to the songs. - A reaction that is visually recognizable and can be described by different parameters. They react to the songs in the music therapy sessions by humming/singing (3/6), singing with text (2/6), reacting on the meaning of the songs e.g. by laughter or comments (3/6), expressing feelings of sorrow/nostalgia (often when song is recognized in the beginning of verse or refrain), tapping the beat (4/6), recognizing phrases (4-5/6), etc.

These responses to the music are documented via the video material. Raw analyses of the sessions with help of the recordings and the time counter already tells me in which sessions and to which songs participants make responses. These data will first of all be displayed graphically with spreadsheets to make an overview. From this material examples can easily be pointed out for close
analyses. External assessors will randomly pick out sessions from the 60 hours video material to control my analyses, which are made upon defined parameters. There must be agreement between our analyses.

There might be a possibility to make these analyses with help of computer software?

**Heart rate** data is very easy to handle as numbers are already in the computer. The gap between the pulse rate when resting and when moving around and being physically active can give a picture of how much a participant is ambulating during the session. Heart rate data might also, when compared with other information!!, give a picture of inner (emotional) activity. Interim analyses of heart rate data pre and post sessions (which were carried through in 3 different periods of the year) seem to show a tendency with all 6 participants towards a reduction in average heart beat pr. Min. On results like this there will be made statistics to see if there is any significance.

**Questionnaires** first of all give information about routines, events and incidents in the daily life that might have an impact on the single session. Is there important information about health? Did the person sleep exceptional long that morning? Were there many visitors the evening before? - Maybe a birthday?

In addition to this the questionnaires gives an overview of behaviour during the day. Questions are posed in a way that answers can be displayed graphically, and this might show some tendencies about behavioural changes in daily life. Data is based on subjective valuation of behaviour made from different staff members knowing the participant well. This is just a smaller part of the project and does not intend to fulfil the demands of a controlled, outcome study concerning a behavioural analyse, but it might support the observation of changes registred in the case description.

**Biography:**

Ph.D.-student at Aalborg University, Institute for Music and Music Therapy. Completed music therapy education in 1989 and worked with music in Bukoba (Tanzania), with teenagers in special education in Tolne (Denmark), with children with different handicaps in Paderborn (Germany) and since January 1995 (until March 2000) as a music therapist at the gerontopsychological unit at the nursing home "Caritas" in Skejby (Denmark). Comments are welcome on: hm@musikterapi.org

**Supervision by:**

1. Inge Nygaard Pedersen, associate professor at the institute for music and music therapy in Aalborg, music therapist, head of the music therapy clinic at Aalborg Psychiatric Hospital.
2. David Aldridge, Chair of Qualitative Research at the Faculty of Medicine at the University of Witten-Herdecke, Germany.

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practice news is a magazine for sharing news about clinical practice and teaching. This month's practitioner is Trygve Aasgaard.

practice showcase:

Musical Acts of Love
in the care of severely ill and dying children and their families

Trygve Aasgaard, MA, is Music Therapist at The National Hospital of Norway, Assistant Professor at Oslo University College, Faculty of Nursing and Lecturer in Palliative Music Therapy at The Norwegian State Academy of Music.

He is presently PhD candidate at Aalborg University, Denmark, conducting a research project about the life-histories of songs made by children with cancer.

Abstract: It is an interdisciplinary responsibility for hospital and hospice staff to provide an environment where love "to" the patient and "from" the patient can be made visible. Music and love have many close connections. The first part of this paper describes and discusses examples where the music therapist, in collaboration with nurses, hospital teachers, medical staff and relatives assists seriously ill young patients to express love and thankfulness. Secondly it describes how parents of dying children can be assisted by the music therapist to say farewell. The final part of the paper focuses on "pleasure" and "joy" as important (underestimated?) therapeutic goals in palliative music therapy and -care.

Introduction

There seems to be an endless variety of how man perceives relationships between "music" and "love". We are loving music. We are expressing love through music. In the history of human
mankind and in many religions, music is often understood as some kind of spiritual matter, being "heavenly", "divine", "the speech of angles", or "a gift of God". So music makes us start loving; and it can perhaps even make us more loveable persons. But music also influences our hormones, our instincts, and our wishes to make love. Music is thus body and soul. That's why music therapists are continuously concerned with music's numerous possible influences on our bodies as well as of our thoughts, emotions, self concept and relationships with other people. When the topic is "love"…or "hate"…we will easily find musical equivalents.

However, considering music therapy practice in the context of love is more complicated. Music therapy is a profession. The music therapist's relation to his clients/patients or even to his "job" is not automatically more characterised by any love-aspects than doctors' or nurses' or, for that sake, a lawyer's or an economist's professional relationships. If we are uncritically applying the numerous general music-love allegories in the practical music therapy contexts (and unfortunately that happens far too often), we are easily falling into the pitfalls of sentimentality or ending up with "mere words". This problem becomes evident in descriptions and assessments of the uses of musical means in palliative care and particularly so in contexts with young patients.

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practice showcase:

Musical Acts of Love (Page II)

in the care of severely ill and dying children and their families

One practical side of the expression of love is doing “good things” to the person being loved. When living in the proximity of death or possible life threatening disease, we are seemingly more aware of small acts of love than during normal times when we are preoccupied with numerous minor (?) problems. I believe I have seen this time and time again in families where one member gets cancer, in paediatric cancer wards and in hospice outpatient and inpatient settings. “Acts of love” have some common characteristics: They are not specifically goal directed more than hopefully being appreciated by the receiver. They are not thought of as necessarily bringing any permanent practical “results”. On the contrary these acts are, first of all, expressions . . . sometimes carefully worked out, sometimes improvised. This paper deals with how a music therapist can assist patients and relatives in the processes of “making love become audible” in the child cancer ward.

Brian’s dreams

"Brian” is 14 years old. Since he was six he has been in and out of hospital because of his Acute Myeloid Leukaemia (AML). He has gross learning difficulties and attends a special school when he is "at home"; he is living with his uncle and aunt. Writing and maths are really not Brian's cups of tea. His social life has been also been disrupted many times because of his illness, hospitalisation and periods of isolation. Now he is in hospital again . . . fatigued and frequently feeling unwell. Teachers, doctors and nurses knowing Brian well experience that his self-confidence is seemingly rather low at the time. Nevertheless: He has started to look at the girls, a rumour also claims that he has fallen in love!

Brian has heard songs made by younger hospitalised patients. Nice songs, but dealing with rather childish themes, Brian states. At the hospital school he learns to use a PC, and one day Brian has actually written his very first, very own song-text: "LOVE”. Grammatical errors are being corrected. And one afternoon the music therapist, assisted by Brian, makes a melody to the text. A nurse informs that Brian
has said (with a smile on his mouth) numerous times that day: "I dread what will happen when Trygve comes". He does not have much strength today; he is bedridden and is receiving a dose of chemotherapy intravenously, but he is eagerly following me conducting the compositional process. Brian chooses the rhythm and speed of the melody and says he wants it to be in "heavy rock style", otherwise he has no melodic suggestions. "Love" is written out nicely, and some days later it is being performed during the weekly "Musical Hour" in the entrance hall of the paediatric department. The music therapists plays the piano and patients, relatives and staff are singing, clapping hands or drumming:

**Love is nice girls and tough boys,**
loving each other, and attending the same school.
"How old are you? Can you say you love me"?
**Then they move together, and that is cosy.**
(translation from Norwegian by T.Aa)

Big applause! Brian has watched the performance from the sideline. He does not sing or say a word himself, but he is blushing and smiling. During the following weeks “Love” can be heard at many occasions in the paediatric department. Brian seems to be particularly pleased that he has participated in the making of a real pop-tune and not just a children’s song.

A soon fifteen year old boy has made “his” own song. It is nothing peculiar about that. The theme of the text is probably the most common you can think of. What may be interesting is to consider the creation and life of this song with the paediatric cancer ward and Brian’s social situation as contexts: a very sick youth in a very restricted social environment where “normality” becomes a luxury. However, when this song is being performed, Brian is seemingly not primarily a patient with a life threatening disease. For some moments he appears to be in the centre of attention just as a normal and creative teenager.

* Staff nurse comments: [This song] was an expression of what Brian thought of as positive in his life. There were so many other aspects that were negative. [One value] in life is actually worth living for . . . and that's love, ok? Surely this has kept him afloat and given him the courage to live.

* Enrolled nurse comments: [...] "move together, and that is cosy" [...] He had a really good time after having moved to his aunt and uncle [...] They often used that expression, "cosy". [...] And Brian had a tremendous need of love".

* Hospital teacher comments: “He was incredibly proud. He grew ‘several feet’ when you made music to his text . . . there were so many other things he did not master at the time”.

Is this account of Brian’s first song in hospital (later he made more) telling something about the music therapist as a catalyst for the patient’s thankfulness, hope, joy and love? Brian never sung himself, at least not for other people. When the music therapist, nursing staff etc. were performing Love, the song had a certain representative function of the patient’s wishes or dreams and need for expression. Both the artistic process and product were testimonies of genuine aspects of health in this youngster even if he was seriously ill at the same time. Numerous limitations of action, an increasingly reduced strength and many unpleasant symptoms now marked Brian’s life situation. He was temporarily not able to do very much on his own. But Brian seemingly liked very much to hear (other people sing) his song. Not very different from a nurse assisting or taking over the patient’s
self-care during illness and infirmity, the music therapist “represented” Brian, supporting some of his healthy and creative, but lesser known sides.

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in the care of severely ill and dying children and their families

The music therapist as a messenger

For eight months Mary’s best friend in hospital has been her primary nurse, Dagny. Mary (8) has experienced a particularly tough time since she was diagnosed as having Acute Myeloid Leukaemia: Persistent emesis, local infections needing surgical interventions, numerous unpleasant and frightening blood tests, pain not easily alleviated by opiates, and months of isolation. Now she has been transferred to another university hospital. Mary shall receive bone marrow from her little brother. She says she is missing her primary nurse who is presently not allowed to visit her because of the strict isolation regime Mary must live under.

Mary is becoming increasingly pain ridden and sick. However, the day before the planned transplantation her general condition seemingly eases a little (according to the father). While she is alone in her new isolate for some few minutes she writes two texts, “Friends” and “I’m bored”. The next morning the father hands the two sheets of paper to the music therapist. Mary has made short texts before and she has improvised songs together with her mother, a hospital teacher and with the music therapist. But this is the first time Mary has written texts originally intended to be sung. “Friends” is a short, funny text with end rhymes. It commences by frankly stating that “Dagny (the nurse) and I are friends”. The next song is longer and actually telling a little story:

I’M BORED
How are you?
Here I am, and I’m bored.
My primary nurse comes to me.
She is reading a book for me,
and when I have pain,
she is helping me.

Her name is Dagny,  
and we are friends  
and make many things together.  
But when I'm feeling sorry,  
she comforts me,  
and we play together.  
And in the evening she comes to me,  
and then I fall asleep.  
(translation from Norwegian by T.Aa.)

One week later Mary asks for the music therapist. The two songs has been preliminary recorded with me singing and playing the piano. The rhythmical texts has not been altered, the melodies come easily. I am also talking to Mary on the cassette, explaining her how I have been dealing with the texts. If she wants to alter the melodies or make completely new melodies, it’s just fine. Mary listens to the recorded songs. She is looking concentrated and is continuously smiling. Then she asks if I can bring the cassette with the two songs to Dagny, if possible already today; the melodies suit the songs ok. Some hours later I am able to deliver the cassette to Mary’s former primary nurse at the other hospital. I can see that she is really touched by this gift from her friend in the "far away" isolation room.

Mary does what she finds naturally in her situation, she makes songs about something really important in her life at the time. She is thinking of and missing a beloved person. An isolated hospital patient’s repertoire of possible choices of actions is understandably very much restricted. In this case we see that "making and giving away a song" is something Mary can create and conduct from her sick room. We do not know exactly why Mary wants to have the songs handed over to the primary nurse as soon as possible. Perhaps does she primarily want to make nurse Dagny happy and give her “a gift; perhaps will she tell she misses the comfort and company of her primarily nurse.

*Mary’s mother comments:* “This is actually a love song to the nurse. This is one way of confirming the warm relationship they have had for a long time”.

*Hospital teacher comments:* “Mary seemingly experienced the text and the music as a symbiosis. The one could not be without the other”. The song [...] shows us the importance of having a companion that can be trusted 1000% while in hospital . . . and even if one have to change hospital for a while.

Music can be understood as a non-verbal language or more correctly as a variety of communicative elements. A song communicates through both textual and musical channels. (Each time a song is played or heard, it is actually a “new” song, because the non musical song-contexts, the human
mind included, always change or develop.) “I’m bored”, addressed to nurse Dagny, is seemingly containing a significant textual message. What the composed music/ the performed music possibly did to the text will not be discussed here. People knowing the texts beforehand and then listening to the song might perceive the verbal content as being amplified, underlined, distorted or destroyed by the music. Perhaps the music added one or more dimensions to the plain text? Mary preferred merry melodies. I therefore composed something I hoped would be perceived as optimistic, even if the title and the start of the text was “boring”. It is also likely that making a tape increased the song’s potentials for being performed or "used". And surely the music therapist was a most willing and happy messenger . . .

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practice showcase:

Musical Acts of Love (Page IV)

in the care of severely ill and dying children and their families

When there is not much more to do

When the music therapist enters the room of a child who is soon going to die, he painfully realises the many limitations of his profession. Music cannot prolong anyone’s life; the music therapist is no Orpheus “who subjugated Hades by his entreaties”, through singing and playing his lyre. Death is often not beautiful at all. When children die, it is always tragic and meaningless, although death can also be perceived as a release from a “meaningless” life situation marked by persistent pain or decay.

“Peter”

There is no more noise from the infusion pump. Most technical devises have been removed from Peter’s bedside. Curative or life-prolonging therapies have come to an end. During the last days all strength has seemingly left the little patient. The four year old boy is lying on his side, with closed eyes; his tummy is large, his limbs are very thin. I have placed myself quite close to Peter, improvising very quietly on a pentatonic lyre. The mother is also in the room. Her tears are running. No words are spoken by any of us.

After a time Peter opens one eye and looks at me. I am surprised; he is perhaps less unconscious than I have been thinking. Familiar with Peter’s musical preferences, I whisper to him: “Shall we sing ‘Hocus-pocus’ “? I believe he is nodding. . . Then, as softly as I can, I start singing about the Jack in the box. Peter interrupts me: “The blanket, the blanket”! I have forgotten to cover his head with a blanket. (In this song the child that is chosen to be the Jack in the box is “hidden” under some kind of cover. The song ends with the words “come forward!”. The “Jack in the box” emerges suddenly, and all bystanders are of course highly surprised.) I cover Peters head halfway with his sheet, sing the song with a brittle lyre accompaniment and remove the sheet most carefully at the end. Peter smiles for a second, but shortly
after he closes his eyes again. He dies the next morning.

“Tommy”
“Tommy”s parents are divorced, but now they have come together to stay with their three year old son in the paediatric oncology ward. We all know that Tommy will not live for many more days. One morning the mother, the father and another relative sing a hymn for Tommy who apparently is sleeping peacefully. A common interest of the parents has been choir activities, and now they are singing the upper parts from a four voice arrangement. Eventually I join them, singing the bass part. It is impossible for me to see if the boy perceives or reacts to our music. “There is so little we can do now, but Tommy has always appreciated listening to us singing for him”, the mother says.

After the aunt has left, I ask the parents if they think I could assist them in some way. The father tells me that Tommy’s favourite song at night time is “Who can sail without wind?”. It had been nice if I could find or make a version for three voices. A couple of hours later I have found what the father asked for in a music library. During the afternoon the three of us sing the beautiful and sad Swedish song for Tommy again and again. After I have left the ward, the parents continue to sing throughout the evening. Tommy dies early next morning. His father says later that he is fairly sure that his boy could hear the singing and that he made some sort of approval when asked if they should sing the song once more.

“Magnus”
Half a year ago Magnus’s brain tumour was seemingly completely removed by surgery and radiation. He started school as a normal six year old kid, but after a month he became continually dizzy and unsteady. An operation revealed a new tumour near the brain stem, unfortunately inaccessible for any curative treatment. Radiation therapy might prolong life somewhat, but Magnus’ future prospects were rather gloomy. The mother tells me that the family has been in a state of shock since the last operation. “We are not able to do much ourselves for Magnus now, but we are most grateful for anyone who can ‘give’ Magnus something now”.

The handsome boy has trouble to keep both eyes open, his face is almost expressionless. Magnus is awake but tired. I have brought a lyre and I play some, probably well known, phrases on a treble recorder. He looks at me. I show him how to touch the stings, and Magnus actually manages to play gently while I sing some lines about the two of us starting up a rock band. Magnus smiles (the mother says this was the first time he smiled since many days). As far as I can see, he mentally drops out after our improvisation, but he nods when I propose we shall record our next session. I leave the pentatonic lyre at the bedside. Magnus’ mother might want to play a little on it.

Three days later I meet the mother again. Magnus is away for an X-ray. He has recently suffered many periods of restlessness, possibly because of a gradually increased pressure on the brain stem. Once when Magnus was shivering, his mother started to pluck the strings of the lyre, and Magnus very soon quietened down. Since this occasion Magnus asked her to play the lyre at several times. One night he woke up and told his parents that he just had been thinking over what kind
of song would be most fun to sing during “the recording with Trygve” in a day or two.

Magnus’ state of consciousness deteriorates rapidly, almost hour by hour, and soon he is out of reach from ordinary communication. No recording, no more fun! He is sleeping day and night. One morning, however, I find a message at the bedside table to me from the mother. She has written on a paper serviette: “Magnus wants to hear ‘Children of the Rainbow’ today. Thanks!” A nurse is sitting at the bedside reading aloud from one of Magnus’ books. And when she has finished the story, anyone coming in the vicinity of Magnus’ room will hear the sounds from a keyboard and the voices of a music therapist and a student singing about “a sky with stars as long as you can see”.

I believe we can consider the examples above as interplays of loveable acts between patients, parents and music therapist. We can still discuss “healing consequences” even when a prolongation of life is out of reach. David Aldridge, one of the world’s leading scholars on music therapy research, claims that:

“Healing is done at a variety of levels, not just for the individual, but within an ecology of relationships [...] Music therapy is not a form of treatment in the medical sense - it is, however, a form of accompaniment” (Aldridge, 1999:24).

Who is "giving" and who is "receiving" are probably less interesting questions than to search out which meanings can be related to these acts or events. When Tommy is nodding or Peter and Magnus are smiling for the last times in their lives, we are witnessing a child’s precious gifts to his parents. But the playing or singing in the sick-room can just as well be understood as a loveable act towards a child. The music therapist is privileged to be able to work "within" such moments that can be highly emotional, moments often remembered for a long time. The parents of Peter, Tommy and Magnus expressed later that the musical events during the last days meant something valuable to them. A more accurate investigation reveals that the “meaningfulness” is not related to only one circumstance. Tommy’s mother said that the musical elements in the sick room were good for the despaired parents themselves, and that being musically active made them feel they did, at least, something for their dying child. They knew he liked the song they were singing. Magnus’ mother told me that she was convinced that the music “had a positive influence” on him. We observed he had some moments with fun; and according to the mother he became more relaxed by the music (or by the musical activity). Our planned small, but unfinished, project also made him look forward to something nice: a dream about a song. Playing Magnus’ favourite song for him, although he was unconscious, was another way of expressing love and honour to a now totally helpless boy. The “Children of the Rainbow” was also sung in his funeral. I could see that Peter’s mourning parents were relieved and grateful by experiencing their son take part in playing, even on his last day of life. They invited the music therapist to perform songs Peter had liked at the funeral in their local village some 500 kilometres away from the hospital.
Through The *Norwegian Childhood Cancer Parent Organisation* I have met and listened to many parents who have lost a child through cancer. In their accounts of the last period of their children's lives, the acts of creativity, the playing, their enjoyment of music or simply humorous events (!) are often included. I do not doubt that the stories are true. Aspects like those being mentioned here give us a more complete picture of the lost child underlining it's humanness, childishness . . . and not the least: the child’s preserved healthy sides . . . in the middle of sickness and process of death. To tell the story of the child can still be an act of love from the parents.

When people are approaching death, in some way or another, the feeling of loneliness can be overwhelming. Singing together certainly helps many experiences they are not alone. Singing together is a strong demonstration of *being* together. At the deathbed of a beloved person the singing together means being active participants. The musical activity can soothe as well as support the mourners and it can promote more or less collective deep and meaningful life experiences.

But is there perhaps something in the described musical examples that cannot be reduced to “function”? Is it a legitimate reason for bringing music to these children by simply stating “because music is music”? I believe people in general (cross-culturally) have a wordless primary understanding of music as being one of the most specific human attributes. This may be one explanation why music is taken as granted when so many are confirming existentially important moments in their lives, from baptism to funeral.

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Conclusion

We have been looking into some of the processes where the music therapist assists patients and relatives “making love become audible” in the child cancer ward. The examples chosen have dealt with fairly basic interactions and few complicated procedures or techniques. The author realises that these descriptions could just as well have been interpreted through quite different kinds of glasses: psycho-dynamically, within a coping perspective etc. I will not completely disagree with someone claiming that the concept of “love” is so vague and has so many sides, that it really does not indicate a clear direction of the therapeutic process if used as a general goal. On the other side I believe that it might be prolific if we, from time to time, reflect on what this much used and misused concept means and how aspects of love appear in our professional practice as well as in our private lives.

The *Oxford Textbook of Palliative Medicine* (Doyle, Hanks and Macdonald, 1993) is an 845 page standard text on how terminally ill people shall be treated (including sections dealing with music therapy to adults and children). In the subject index we find many entries on “loss”, but nothing on “love”, lots about pain and pain reducing therapies but nothing about “pleasure” or “joy”. Simply aiming at providing pleasure, fun, a loveable environment, or supporting the patient’s healthy sides are seemingly not always highly ranked therapeutic goals. But that does not mean such actions or aims are non existent in today’s practice, they rather belong to the realms of “silent knowledge” and “silent actions” amongst health workers and members of the creative therapy professions. The loveable moments in the care of very sick or dying patients are frequently experienced, sometimes being thought of and talked about, but seldom a topic regarded as sufficiently important for systematic exploration and reflection. And true enough: It is not easy to measure, quantify and grade either love (except reproduction) or *musical experiences*. But this fact does not reduce the significance of love and music in our lives on earth.

References


Trygve Aasgaard, MA, is Music Therapist at The National Hospital of Norway, Assistant Professor at Oslo University College, Faculty of Nursing and Lecturer in Palliative Music Therapy at The Norwegian State Academy of Music. He is presently PhD candidate at Aalborg University, Denmark, conducting a research project about the life-histories of songs made by children with cancer.
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peterh@uni-wh.de

practice showcase:

Aspects of music therapy
on the psychiatric ward for adults at the Herdecke Community Hospital

The department

The psychiatric department for adults at the Herdecke Community Hospital (http://www.gemeinschaftskrankenhaus.de) is a relatively small psychiatric unit with a total of 34 beds. It comprises three wards: a psychiatric and a psychotherapeutic ward, and a closed ward (or open, as may be required) with eight beds. The department has a psychiatric outpatient ward and also a day care unit affiliated to the hospital with 20 beds, to which in-patients may also be referred. Music therapy forms part of a very wide range of different treatment approaches within an anthroposophical context.

The department offers

- psychotherapy
- drug therapy (including anthroposophical drug therapy)
- art therapies (painting, sculpturing, music therapy)
- eurythmics and drama therapy
- handicraft therapy
- workgroups (fairy tales, cooking, weaving)
various sports activities
behavioral and psychoeducative therapies
individual care
a social service unit.

The treatment concept is geared to the individual's needs and possibilities, comprises single and group therapies and takes a patient's social context into account wherever possible. The department provides a support group for family members.

Clients/Patients

Clients/patients on this ward, irrespective of individual diagnosis, suffer mainly from the following symptoms:

- fear
- a high degree of insecurity
- contact / relationship disorders, differentiation problems
- perceptual disorders
- emotional limitations, altered sensation
- reduced impulse
- changed perception of environment and/or reality
- impaired activity
- impaired mental processes and speech capability
- changed body perception
- vegetative symptoms (palpitation, vertigo etc.)

The individual diagnosis may be:

anxiety and compulsive neuroses
depression
addiction and personality disorders
psychoses.

Music therapy

The type of music therapy employed in Herdecke is based on the Nordoff/Robbins creative music therapy (Aldridge 1997-2001, Ansdell 1994, Nordoff/Robbins 1986). In musical encounters we seek to discover the individual patient's music and to make it ring out. The idea is to help patients to find their individual expression in music-making, and to open up ways to develop their perception and performance, a performance which may be impaired, restricted or insufficiently developed due to personality disorders or disease. The individual patient may thus discover or recover his/her own potential for feeling, perceiving and acting.

Music is a meeting place, allows nearness and deep-felt encounters. It is performed by therapist and patient alike, whereby the therapist accompanies and encourages the patient's music-making on the basis of the potential and response inherent in musical dialogue.

Music therapy is a form of treatment in its own right, and understood and employed as a therapy complementing others.
Encounter and dialogue in improvised music

A short musical example may serve to highlight some ideas on "aspects of encounter - ways towards dialogue" which I consider of particular importance.

A 28-year-old patient - without previous musical experience - has chosen a metallophone. She starts to play a melody which I take up on the piano. Immediately, a form of joint music-making has emerged which I feel to be characterized by contact and moments of encounter.

Ex. 1

Without giving more details on the patient, I continue with a more general description of the situation: Both participants do not know what to expect before they start to play. They experience a state of "insecurity". This state of "not knowing" - as to what will happen and what the other person is going to offer - requires an attitude of listening, of searching for and approaching what is to follow. The "metallophone" starts, and sets up a melodious gesture. The "piano" tries to take up the gesture - and is again taken up by the "metallophone" after some time. Individual activities on each instrument combine to form a joint activity, not only in sequence but also simultaneously. A musical form emerges which is performed by both and taken up by both. Both persons take up and perform, in synchronization.

A joint activity performed like this allows for co-movement, co-sensation, following the activity of the other. Such a co-movement - with its mental and physical dimensions - offers an opportunity for empathy, for a sympathetic perception of the other person. Such empathy may only emerge from an effort for encounter. This applies likewise to the spoken word, to music or other therapeutic media.

In such a relationship, the therapist is challenged not only to understand rationally but also to make himself available as a person with his sensory perceptions and emotions. The psychiatrist Schmid-Degenhardt described this as "...not so much scientific method but rather practical human work" (Schmid-Degenhard 1994). The most essential requirement for a therapist is a listening attitude in order to perceive what the client does, or wants to do, and to be able to offer what the client needs. This is easier said than done. To achieve and maintain a listening attitude is an essential requirement and also a great challenge. In contact with clients or patients, the listening process must not be ended prematurely ("now I know what this is about") by a quick, rational classification. On the other hand, a listening, open and active perception of a patient may also hold a certain risk: to be led by a patient to a point which the therapist had never intended - or believed possible - to reach. A patient may thus become the guide of his own therapist, may have "guidance competence", according to the psychiatrist Klaus Dörner (Dörner 2000). As a musician, I should say he is the conductor of our joint music-making.

The obvious significance of the encounter concerns the quality of the relation between client/patient and therapist. However, the encounter involves a further dimension, that is the "encounter" of a patient with himself through - or rather in - the music performed by him, and through the emerging dialogue. A patient may perceive his own limitations and potentials in this encounter, his individual characteristics are reflected in the music and the partner in dialogue, as well as opportunities for development. A patient/client may address his own modes of acting or perceiving in the music-making, may develop a new or different view of himself. This emerges in the course of a process which is truly artistic, i.e. undergoing various stages of coping with the musical material. In most cases, the first step (a) is an unconscious, 'naive' testing of the unknown instrument, followed by (b) actively exploring what is possible. In perceiving and discovering qualities emerging from the
material in the process of exploring (c), the music-making patient then enters into a dialogue with the material (d). This last step is characterized by activities like perceiving and performing, giving and taking in a figurative sense, and resembles a dialogue. Ideally, the music performed by the therapist offers the basis for such a process, leaving room for the experimental "dialogue" of a patient with the instrument, leaving room to discover the music and one's own nature and potential in this process. My concern is to point out that in inviting a patient/client to make music, we must be generally aware of these different paths towards dialogue, although they are closely related to each other: the "encounter" of a patient/client with himself, with the music, and with the therapist.

Patient cases

Several cases which are narratives of various encounters with patients may serve to describe practical music therapy in my field of work. In all cases, the basic attitude of striving for encounter is certainly audible. Consequently, I shall focus on music therapy and deliberately neglect other aspects of treatment and care which are of clinical significance. 

(For reasons of data protection, it is not possible to publish all cases presented at the conference including the pertinent audio illustrations. The names of the patients described below have been changed.)

Herr Becan

Herr Becan is 31 years old. A few years ago, he came to Germany to work in the gastronomy sector, until his illness became evident two years ago. Our first meeting: I do not know much about him. His outward appearance suggests southern/mediterranean origins; short black hair; rather short built. He is very slow, appears fearful. I have no idea how advanced his German is, since he practically does not speak, and wonder if he understands me at all. The staff on the ward face the same problem: Herr Becan is isolated, without contacts, almost mutistic. Diagnosis on admittance: Herr Becan suffers from paranoid hallucinatory psychosis, with delusions, hearing of voices, forced thinking, delusion of being influenced. Prior to admission, he was almost stuporous.

In the music therapy room, Herr Becan is unable to choose between instruments. However, as soon as I give him a drumstick and ask him to play he immediately starts a musical activity.

The following example is taken from our third session. Herr Becan plays the drum with a drumstick, producing "unclear rhythmic shapes" which are difficult to follow. I try to accompany his music, to make contact, which is audibly hard for me.

Example 2

For moments, he atunes his activity to the piano music, something like a communicative intention emerges for short instants and then is lost again. The example shows a relation in imitation and subsequently an exact orientation in tempo.

In accompanying him, I learn that although my playing must be geared to taking up his movements, he himself may only find orientation if I disengage from his playing. My musical activity shows an engagement with his music and a disengagement via musical motifs taken from his playing. There is a continuous alternation between taking up, offering etc.

In my efforts to accompany his activities, to follow him, to listen, I experience individual qualities of expression and performance, qualities which alternate between structured and unstructured, oriented and unoriented, between relationship and "separate world", between isolation and sporadic
contact.
The music thus allows sensory perception of something which expresses his actual condition. The first music therapy session shows that it is possible to make contact for short moments. Music seems to reach him in his isolation, to offer him ways to feel and to develop expression and contact. In the following sessions, Herr Becan learns how to direct and orient his activities better. He is more and more able to take up elements of the music offered, our play now involves frequent imitation. His music is mainly geared to my playing, he seems to be unable to add something of his own. I take into account that he needs my stimuli for structure and orientation. Some very simple songs emerge in our sessions which we sing together. An improvisation in our tenth session becomes a song with a small improvised part. Herr Becan is unable to sing the song with confidence but gains orientation from the reliable form and the repetitions offered. The improvised part contains imitations which allow for another direct, although "copying" relationship. From then on, something like a sense of form emerges very tentatively. Herr Becan appears to perceive musical forms more clearly and take them up more intensively. He is able to anticipate some song elements, develops a limited capacity to pre-listen, to form perspective and direction. The time element in his activity, momentary at first, gradually gains in volume and roundedness.

The following example from the twelfth session may serve to illustrate this development.

Herr Becan and I sing, improvising clearly structured phrases of a folk-music type. Herr Becan follows the melody of the phrase with his voice and shows that he is developing a sense of musical form. It becomes quite obvious that in order to do so he needs the musical offer of contact. He performs "in the shadow" of my stimulus. In the course of the example, we hear repeated imitation situations where I can now accompany him on the piano.

After 4 months, Herr Becan is released on probation, at first on a day-to-day basis, and then referred to the day care unit.
Contact in musical encounters helped him to develop orientation and structure for his activities, to gain some degree of confidence in perceiving, performing and shaping the relationship. He was able to make contact - albeit short and tentative. He lost some of his rigidity, as could be felt mainly in his singing.
The staff on the ward reported similar observations on different levels: in his general activities, he shows more structure and orientation, in contacts, he is more flexible, but frequently still taciturn and withdrawn.

Herr Ehrlich

After prolonged hospitalization, Herr Ehrlich is referred to music therapy sessions as an outpatient. He is in his late thirties and for many years has been suffering from schizzo-affective psychosis with frequent depressions. Herr Ehrlich loves music, often listens to music and plays the mouth-organ. At the time of our first meeting, his medical caregivers believe him to have difficulties in every-day life to accept social responsibilities and structures and often to harbour unrealistic ideas. He is termed unreliable in social relations and his ability to commit himself is doubted.
In music therapy, which I start without any knowledge of this diagnosis, I meet a person who immediately takes up musical activity and is able to experience and benefit from its expressive and performative potential. His play shows a high degree of expressive intensity, flexibility, fine perception for mutuality, openness for contact and engagement.
In the following example (consisting of three excerpts from an improvisation) Herr Ehrlich has chosen a melodica and starts to play; at first he experiments with the instrument. Subsequently, a peaceful music develops which becomes rather lively and then again tranquil. This music makes evident that Herr Ehrlich has a high level of attention, marked sensitivity and an active willingness to enter into a mutual relationship, and also that music releases creativity: for him, music obviously is an area where he may experience and enjoy his personal identity in a very comprehensive sense.

Examples 3, 4, 5

This example suggests that different therapists may have differing and even contradictory perceptions of one and the same patient. In a clinical setting, exchange between therapists and care-givers is of great importance, also dialogue with the patient himself in order to review assessments and evaluations and place them in the appropriate context.

Conclusion

Let me come back to the attitude of "striving for encounter" mentioned at the beginning, which I called the basis for empathy, accompaniment and understanding. The examples demonstrate that this attitude may be combined with very different types of behaviour and musical techniques, in accordance with the specific situation and the requirements of the individual patient: cautious accompaniment, active joining in, advancing, offering, imitating, contrasting, opposing etc. But in each case, the music therapist must listen carefully in order to perceive and encourage a patient's potential. A story I recently heard from the psychiatrist Klaus Dörner (Dörner 2000) underlines the intended, empowering meaning of listening for the therapeutic encounter:

A woman told her therapist she was afraid to allow anybody to help her.
He asked for the reason, and she answered:
"Because I am afraid that somebody might wish to help me."
"What is it you want?" he asked.
"That somebody listens to me until I have found a way how to help myself."

References:

practice news is a magazine for sharing news about clinical practice and teaching. This month’s practitioner is Peter Hoffmann. You can contact him at:

peterh@uni-wh.de

practice showcase:

Aspekte zur Musiktherapie
in der erwachsenenpsychiatrischen Abteilung des Gemeinschaftskrankenhaus Herdecke

Die Abteilung

Die erwachsenenpsychiatrische Abteilung des Gemeinschaftskrankenhauses in Herdecke (http://www.gemeinschaftskrankenhaus.de) ist mit insgesamt 34 Betten eine vergleichsweise kleine psychiatrische Abteilung. Sie ist unterteilt in drei Stationen, einer psychiatrischen, einer psychotherapeutischen, eine fakultativ zu schließenden mit acht Betten. Es gibt eine psychiatrische Institutsambulanz ebenso eine dem Krankenhaus angeschlossene Tagesklinik mit 20 Betten, in die auch Patienten aus dem stationären Kontext überwiesen werden können. Die Musiktherapie ist eingebettet in ein Behandlungskonzept mit einem sehr breiten Spektrum, das von anthroposophischen Impulsen und Konzepten für die Behandlung gekennzeichnet ist:

Es gibt:

- Gesprächstherapie (in der Regel tiefenspsychologisch fundiert)
- medikamentöse Therapie (einschließlich anthroposophisch erweiterter medikamentöser Therapie)
- künstlerische Therapien (wie Mal-, Plastizier- und Musiktherapie)
- Eurythmie und Dramatherapie
- Werktherapie
- Märchen-, Koch- und Webgruppen
- unterschiedliche Sportangebote
- verhaltenstherapeutische und psychoedukative Verfahren
- individuelle Bezugspflege
- einen Sozialdienst.

Das Behandlungskonzept ist stark am Einzelnen und seinen Bedürfnissen und Möglichkeiten orientiert, beinhaltet gleichermaßen Gruppen- wie Einzelangebote und ist bestrebt, das familiäre Umfeld aufzunehmen. Im Stationskontext wird eine Angehörigengruppe angeboten.

**Die Klienten/Patienten**

Die Klienten/Patienten dieser Abteilung werden in ihrem Sein diagnoseübergreifend vor allem durch folgende Leidenssymptome geprägt (Auswahl):

- Angst
- hohe Selbstverunsicherung
- Kontakt- Beziehungsstörungen, Abgrenzungsprobleme
- Wahrnehmungsstörungen
- Gefühlseinschränkungen, Veränderungen des Erlebens
- Antriebsstörungen
- Veränderungen des Welt- Realitätsbezuges
- Beeinträchtigungen des Handelns
- Denkbeeinträchtigungen, Sprachbeeinträchtigung
- veränderte Körperwahrnehmung
- vegetative Symptome (Herzrasen, Schwindel etc.)

Dahinter verstecken sich im Einzelfall ganz unterschiedliche Diagnosestellungen:

Angst- und Zwangserkrankungen
Depressionen
Sucht- und Persönlichkeitsstörungen,
Psychosen.

**Die Musiktherapie**


Die Musik ist Begegnungsfeld, sie ermöglicht Nähe und tiefe Begegnung. Sie wird vom Therapeuten wie Patienten gleichermaßen gestaltet, wobei der Therapeut das Spiel des Patienten
begleitet und unterstützt. Er orientiert sich dabei an dem, was ihm an Potential im dialogischen Miteinander entgegenkommt. Musiktherapie ist als eigenständiges Verfahren in den Behandlungskontext integriert und wird als Ergänzung zu den anderen Verfahren verstanden und eingesetzt.

**Begegnung und Dialog in der improvisierten Musik**

An einem kleinen Musikbeispiel möchte ich einige mir wichtige, übergeordnete Aspekte zum Motto "Aspekte der Begegnung - Wege zum Dialog" deutlich machen.


**Bsp. 1** (mp3, 537 kb)

Ohne auf die Patientin im Speziellen weiter einzugehen, möchte ich die Situation übergeordnet genauer beschreiben: Beide Beteiligten wissen - bevor sie zu spielen anfangen - nicht, was kommen wird. Sie befinden sich in einem Zustand der 'Ungewißheit'. Dieser Zustand des 'Nicht-Wissens' - in Bezug darauf, was sich ereignen wird und was der jeweils andere im gemeinsamen Spiel anbietet - verlangt nach einer Haltung des Hörens, des Suchens und des Begegnens für das Folgende. 'Das Metallophon' beginnt, setzt eine melodische Geste in den Raum. 'Das Klavier' versucht die Geste aufzugreifen, zu begleiten, - darauf bezieht sich nach einiger Zeit wiederum 'das Metallophon'. Aus den Aktivitäten der Einzelnen an ihren Instrumenten entsteht etwas Gemeinsames, nicht nur im Nacheinander, sondern auch in der Gleichzeitigkeit. Es entsteht eine musikalische Form, an deren Gestaltung beide Personen teilhaben, auf die sich beide wiederum beziehen. Beide Personen **beziehen sich und gestalten** gleichermaßen, und zwar zeitgleich, synchron.


In einer solchen Beziehung ist der therapeutisch Tätige nicht nur als rational Verstehender gefragt, sondern gefordert, sich mit seinen Sinnen und seinen Empfindungen als Person dem anderen zur Verfügung zu stellen. Und das ist - wie der Psychiater Schmidt-Degenhardt sagt - "...weniger wissenschaftliche Methode als mitmenschliche Praxis" (Schmidt-Degenhard 1994). Wichtig dazu ist eine hörende, lauschende Haltung, um auf greifen zu können, was der andere tut, was er tun möchte und um anbieten zu können, was er zur Verwirklichung dessen benötigt.

Das ist leichter gesagt, als tatsächlich getan. Es ist eine große Herausforderung wie eine Notwendigkeit, eine hörende Haltung zu pflegen und zu bewahren. Dies meint im Kontakt mit Klienten oder Patienten, das Hören nicht vorschnell - vor-weg-nehmend - durch ein "Jetzt weiß ich, wo es lang geht" oder durch eine schnelle, rationale Kategorisierung zu beenden. Eine lauschende,


Fallbeispiele


Herr Becan

Herr Becan ist 31 Jahre alt. Vor einigen Jahren kam er aus dem Ausland mit seiner Familie nach Deutschland und arbeitete in der Gastronomie, bis vor zwei Jahren seine Erkrankung begann. Zu unserer ersten Begegnung: Ich weiß nicht viel von ihm. Er hat ein südländisches Äußeres, schwarze kurzgeschnittene Haare, ist relativ klein. Er ist sehr verlangsamt, wirkt sehr ängstlich. Ich weiß nicht, wie gut sein Deutsch ist, da er so gut wie nicht spricht. Ich frage mich, ob er mich...

Im Musiktherapieraum ist Herr Becan nicht in der Lage Instrumente zu wählen. Allerdings nimmt er unmittelbar eine musikalische Aktivität auf, als ich ihm einen Trommelstock gebe und ihn auffordere auf einer Trommel zu spielen.

Das folgende Beispiel ist aus der dritten Sitzung. Herr Becan spielt auf einer Trommel mit einem Schlegel. Es entstehen schwer mitvollziehbare "unklare rhythmische Gestalten". Ich versuche, was Herr Becan macht musikalisch zu begleiten, Kontakt herzustellen, was mir hörbar schwer fällt.

Bsp. 2 (mp3, 466 kb)

An der Klaviermusik ordnet sich für Momente seine Aktivität, zum Teil blitzt etwas wie eine kommunikative Absicht auf, dann verliert sich dies wieder. Im Beispiel kommt es zu einem Bezug in der Imitation, daraus folgend zu einer genauen Orientierung im Tempo.

Ich bemerke im Spiel mit Herrn Becan, im Begleiten seiner Aktivität, dass mein Spiel sich zwar an einem Aufnehmen seiner Spielbewegungen orientieren muß, sich für ihn eine Orientierung allerdings erst durch ein Lös en meinerseits von seinem Spiel ergibt. Mein musikalisches Handeln ist stark geprägt von einem Eintauchen in seine Musik und einem Lös en daraus mit musikalischen Motiven, die sich aus seinem Spiel ergeben. Es entsteht ein steter Wechsel von Aufnehmen, Anbieten usw..

Im Versuch, seine Aktivitäten zu begleiten, im Versuch mich mitzubewegen, mich einzuhören, erlebe ich individuelle Ausdrucks- und Gestaltungsqualitäten. Qualitäten, die zwischen Strukturlosigkeit und Strukturierungsversuchen, zwischen Orientierungslosigkeit und anlehrender Orientierung, zwischen Bezugsnahme und 'eigener Welt', zwischen Isolation und sporadischem Kontakt hin und her schwanken.

Damit wird in der Musik etwas sinnlich erlebar, was Ausdruck der momentanen Befindlichkeit von Herrn Becan ist. In der Musiktherapie der ersten Sitzungen zeigt sich, daß es für kurze Momente möglich ist Kontakt zu finden. Die Musik scheint ihn in seiner Isolation zu erreichen. Sie gibt ihm selbst Möglichkeit zum Erleben und zur Entwicklung von Ausdruck und Kontakt.

Im weiteren Verlauf der Musiktherapie kommt es dazu, daß Herr Becan seine Aktivitäten stärker führen und ausrichten kann. Immer mehr kann er auch Elemente der angebotenen Musik aufgreifen, regelmäßig ergeben sich in unserem Spiel nun Imitationssituationen.

Sein Spiel ist meist stark anlehnend, orientierend an mein Spiel, etwas 'Eigenes' hineinzubringen, scheint ihm nicht möglich. Ich richte mich danach, dass er zu seiner Strukturierung und Orientierung meine Angebote braucht. Im Verlauf entwickeln sich nur ganz einfache Lieder, die wir gemeinsam singen. So entsteht aus einer Improvisation in der zehnten Sitzung ein Lied mit einem kleinen Improvisationsteil. Herr Becan kann das Lied nicht verläßlich singen, aber durch die verläßliche Form und die angebotenen Wiederholungen gewinnt er Orientierung. Im Improvisationsteil ergeben sich Imitationen, die wiederum eine direkte, wenn auch 'kopierende' Bezugsnahme ermöglichen.

Das folgende Beispiel aus der zwölften Sitzung illustriert das.


_Herr Ehrlich_


_Im folgenden Beispiel (das aus drei Ausschnitten einer Improvisation besteht) hat sich Herr Ehrlich eine Melodica ausgesucht und beginnt zu spielen, zunächst ausprobierend, er macht sich mit Spielmöglichkeiten bekannt. Im Verlaufe entwickelt sich eine zunächst ruhige, dann ziemlich lebendige Musik, die wiederum in einen_

**Bsp. 3,4,5** (mp3, 1062 kb)

Dieses Fallbeispiel deutet an, wie unterschiedlich, gar gegensätzlich die Wahrnehmungen von einem Patienten durch die Therapeuten sein können. Im klinischen Zusammenhang ist hier der Dialog zwischen den Betreuern und Behandlern gefordert, besonders auch der Dialog mit dem Patienten selber, um Einschätzungen und Bewertungen jeweiliger Verläufe hinterfragen und entsprechend einordnen zu können.

**Zum Schluß**

Ich möchte zurückkommen auf die am Anfang erwähnte Haltung des 'Strebens nach Begegnung', die ich als Grundlage für Einfühlung, Mitvollzug und Verständnis bezeichnet habe. Aus den Beispielen ist deutlich geworden, dass diese Haltung mit ganz unterschiedlichem Verhalten und musikalischen Techniken in der jeweiligen konkreten Situation verbunden ist, je nachdem, was die Begegnung mit dem einzelnen Patienten erfordert, was der einzelne Patient fordert. Dies kann ein zurückhaltendes Begleiten, ein aktives Mitgehen, ein 'Vorgehen', ein Anbieten, ein Imitieren, ein Kontrastieren, ein Gegenüberstellen u.a. sein. Immer geht es dabei aber um ein Wahrnehmen und Unterstützen der Potenziale des Anderen aus dem Hören heraus. Die abschließende Geschichte, die ich kürzlich von dem Psychiater Klaus Dörner (Dörner 2000) hörte, weist auf die gemeinte, ermöglichte Bedeutung des Hörens für die therapeutische Begegnung:

_Eine Frau sagt ihrem Therapeuten, sie habe Angst sich helfen zu lassen._
_Auf seine Frage nach dem "Warum" sagt sie:_
_"Weil ich Angst habe, daß mir jemand helfen will."_
_"Was wünscht Du Dir?" fragt er._
_"Das mir jemand zuhört, solange bis ich gefunden habe, wie ich mir helfen kann."_

**Literatur:**

Editorial

from the Chair of Qualitative Research in Medicine. Science serving society; an academic alliance

We are currently engaged in a project that is bringing together various music therapy initiatives as www.musictherapyworld.net. Musictherapyworld.net will develop new tools that will bring parts of the academic world that are not yet participating in the information revolution, namely humanities sections, into the new world...

more...

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New online-articles: Inge Nygaard Petersen, Elke Paulsen, Franz Plum

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research showcase

This month’s researcher is Sarah Burns

Title of research project: 'An Exploratory and Investigative Study into the Therapeutic Effects of Group Music Therapy with Recently Diagnosed Cancer Patients'

read article

research links

Research links will bring together web links to various research sites.
NEW: Research News from Austria

research methods

"A review of references in the medical literature" (David Aldridge, Feb' 2001)
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Editorial

from the Chair of Qualitative Research in Medicine
Science serving society; an academic alliance

We are currently engaged in a project that is bringing together various music therapy initiatives as www.musictherapyworld.net. Musictherapy world.net will develop new tools that will bring parts of the academic world that are not yet participating in the information revolution, namely humanities sections, into the new world. Our wish at the Institute here at the University of Witten Herdecke is to become a partner for others. The old world of conventional publishing is coming to an end and our intention is to offer an alternative that is cooperative and financially accessible to those organisations that have little or no funding for published material. As an Hungarian doctoral student in music psychology recently wrote

"You know, the website gave me back my enthusiasm for research, and I am very grateful for that".

One important feature of any new system is a method of publishing papers that does not involve conventional journals. The academic world is often critical and angry about actions by publishers and this may be one solution. Rapid, multilingual publishing is my intention for "Research News" and "Practice News" on the website musictherapyworld.net

Commercial publishers are charging unreasonable prices for their services. Part of the musictherapyworld.net role will be to develop ways of lowering the costs of the process of scientific publishing by making articles freely available. One of the issues that we will have to face is how to co-ordinate a single nationwide project. Each institute has developed their own working practices. There is no central library, and currently each library within the institutes runs its own catalogues. Many individuals have developed their own digital libraries, some of which are very powerful, but it is impossible for individuals or small research groups to replicate the facilities that can be provided by a high standard library. My intention is to provide a central library of freely available resources for music therapy practice and research. A central feature of any academic initiative is that of knowledge transfer. The main vehicles of this knowledge transfer are the publication of research results, the on-going training and education of junior scientists and press and public relations work.

To meet the need for the publication of research results in professional journals of national and international repute we have the online magazines Research News and Practice News on the website musictherapyworld.net. This is combined with an innovatory database that allows free
access world-wide to researchers interested in the creative arts therapies. This database is itself part of an internal University partnership and has been made in cooperation with the University of Osnabrück. The musictherapy database is combined with an extensive "In-house" library here at the Institute and we still distribute a CD-ROM regularly of new musictherapy materials and information regarding the resources that we have here in the Institute. Information alone is not enough and our informations systems are combined with on-going training and education of junior scientists so that they can assume responsible positions in all areas of society. Apart from a growing pool of doctoral candidates at the Chair of Qualitative Research in Medicine, we are also planning two International PhD projects; one in "Qualitative Research in the Expressive Arts" and the second "Qualitative Research in Counselling, Therapy and Care". Both of these PhD courses will be interdisciplinary and part of an in-service training for those currently employed.

While we are an academic institution, we also need to maintain rich contacts our sponsors and with the broader community. Press and public relations work to make the newest results known to as broad a public as possible and the website allows us to keep the world informed of what we are doing. Interested partners for international cooperation are welcomed either as academic partners in an academic alliance or as sponsors for publishing initiatives.

We have not abandoned the world of conventional publishing entirely, as the new music therapy book KAIROS V Musiktherapie mit Kindern shows. This book is a series of case studies about music therapy containing a photographic essay by Horst Wackerbarth on children that have played with us here in the institute.

David Aldridge
Research news is a magazine for sharing research news. This month’s practitioner is Sarah Burns.

research showcase:

Sarah Burns

Research Project:
'An Exploratory and Investigative Study into the Therapeutic Effects of Group Music Therapy with Recently Diagnosed Cancer Patients'

Sarah Burns is a registered music therapist who following her own diagnosis of cancer, over 15 years ago, decided to use her musical skills (professional musician and woodwind instrumental teacher) to help other cancer patients. She completed her 4-year music therapy training at the University of Queensland, Australia during which time she developed a number of music therapy programmes with cancer patients. Sarah currently works as a music therapist at the Sunshine Coast Cancer Help Centre (SCCHC), a centre whose philosophy of holistic (mind, body, spirit) health care is based on the internationally renowned Bristol Cancer Help Centre in the UK.

In 1998 Sarah was invited and accepted an invitation to carry out research at the Bristol Cancer Help Centre (BCHC) for one year. This study was a collaborative ‘pilot’ research project which combined qualitative and quantitative research methods in an attempt to discover the therapeutic effects of music therapy with cancer patients attending the one week residential programmes at the CHC (see Burns, Harbuz, Hucklebridge and Bunt, 2001 and Bunt, Burns and Turton, 2000).

The positive outcomes of the Bristol research has provided the impetus for and foundations of Sarah’s current proposed PhD research. Sarah’s research will focus on the ‘recently diagnosed cancer patient’ (up to six months of diagnosis) as this is the area in which Sarah believes music therapy has the optimum potential to help the cancer patient, alongside orthodox medical treatment, through the initial stage of their journey with cancer and impact on their overall quality of life.
Research Proposal
'An Exploratory and Investigative Study into the Therapeutic Effects of Group Music Therapy with Recently Diagnosed Cancer Patients'

Rationale for proposed research
Music therapy literature has indicated that music therapy with cancer patients can:

- act as a distraction from pain, promote relaxation, reduce anxiety, tension, stress and relieve depression (Bailey, 1983, 1985, 1986; Coyle, 1987; Davis and Thaut, 1989; Folley, 1983; Magill-Levereault, 1993; Mandel, 1996; McCafferey, 1990; Rider, 1987; Webber, Nuessler & Wilmanns, 1997; Zimmerman, Pozel, Duncan and Schmitz, 1989.
- address issues of spirituality and hope (Aldridge, 1995).
- enhance verbal and non-verbal communication (Jackson, 1995, Bunt & Marston-Wyld, 1995)
- reduce social difficulties and isolation (Porchet-Munro, 1995)

My own experience, observations and music programme evaluations have indicated that music therapy with cancer patients can:

- aid self-expression, creativity, verbal and non-verbal communication
- enable cancer patients to connect with their 'inner child', feel supported, have fun and share laughter
- give choice and empowerment
- help create a positive outlook

My formal music therapy research at the Bristol Cancer Help Centre, UK has indicated that music therapy can:

- affect immune response
- alter levels of tension, stress and energy
- improve mood and sense of well-being

The majority of music therapy research with this population has been in the area of palliative care, is either 'single case'/small group studies and often involves a 'one off' music therapy treatment.

Aims of Research
This research is both a development and extension of my therapy work and the Bristol 'pilot' study and aims to rigorously investigate the therapeutic effects of 'on-going' group music therapy with recently diagnosed cancer patients in order to:

- compare the benefits of listening to music in a relaxed state with the benefits of active improvisation
- discover how music therapy can help the recently diagnosed cancer patients through the
initial stage of their illness

- discover whether music therapy enhances their coping skills and mental adjustment to cancer thus impacting on their quality of life at the outset of their journey with cancer
- give more understanding of the potential benefits of music therapy with this population
- help music therapists provide a more effective service for this population
- add to the music therapy literature

Research Questions
How can group music therapy impact on the recently diagnosed cancer patient's quality of life at the outset of their journey with cancer?

What are the differences between the effects of listening to music in a relaxed state and active improvisation with recently diagnosed cancer patients?

Method

- Recruitment via Sunshine Coast Cancer Help Centre, general practitioners, surgeons and oncologists of 36 recently diagnosed (up to 6 months of diagnosis) male/female cancer patients, age 'open'.
- 12 participants assigned to one of 2 music therapy groups and a 'wait list' group
- Music therapy group A and B to receive one music therapy session of one and a half hours duration per week for 10 weeks
  - Group A to receive 5 weeks of 'listening' followed by 5 weeks of 'improvisation'
  - Group B to receive 5 weeks of 'improvisation' followed by 5 weeks of 'listening'
  - Group C to receive standard medical treatment and be offered music therapy later in the study

Triangulation quantitative/qualitative methodology of:

- Psychological questionnaires
- Patient diaries
- Semi-structured 'in depth' interviews
- Researcher self journalling
- Quantitative data to be subjected to descriptive statistical analyses
- Qualitative data analysed to identify recurrent themes present and to further explore the meaning and process of each individual's experience of music therapy
- All music therapy sessions to be audio-taped with permission of participants

Limitations of study

- Possible attrition due to nature of illness and its treatment
- Participant variability due to:
  - individual differences
  - cancer type, stage, treatment
Current status of research and outline

- Full literature review and research proposal completed in December 2000
- Statement of Intent accepted by university academic board in February 2001
- Ethics clearance currently in progress
- Recruitment campaign to proceed in April/May 2001 subject to ethical clearance
- Music therapy programme to commence in June 2001

Supervisors

Primary: Dr Angela Coco - School of Social Sciences, University of Queensland
Associate: Dr Stephanie Hanrahan - School of Psychology, University of Queensland
Associate: Dr Pam McGrath - Department of Public Health, Queensland University of Technology

Bibliography:

Palliative Care; 9 (4): 42-48

conferences:

**Formen der Begegnung - Wege zum Dialog**
**Musiktherapie in der Psychiatrie**

**Music therapy: Performances and narratives**

David Aldridge

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 practises 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 understood. 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
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 Karajan, 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 Karajan 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 per-form-ances. Thus we need an authored identity to express the distress in a coherent way with others to generate intelligible accounts. 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 lends 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 patientís 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, suffer. 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 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 ñ 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. 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.

conferences:

Form(ation)s of Encounters - Ways to Dialogues.

By Inge Nygaard Pedersen. DK
Aalborg University.
Aalborg Psychiatric Hospital.

"(The maxim)" "It is the relationship that heals - is the single most important lesson the psychotherapists must learn. There are no more self-evident truth in psychotherapy; every therapist observes over and over again in clinical work that the encounter itself is healing for the patient in a way that transcends the therapists theoretical orientation."
(Yalom 1980)

I am an Associate Professor at Aalborg University where I am responsible for teaching the music therapy students on the 5 year full-time Master's programme, and doing administrative work. For 40 % of my working time I am based at Aalborg Psychiatric Hospital who buy my time from the University. I am the Head of the Music Therapy Clinic - A Center for Treatment and Research, where I am responsible for department administraion, clinical work, documentation and research.

Due to these joint responsibilities, my case load is limited to 3 to 4 individual cases at a time. The Clinic, which started in 1994, is a jointly funded service where costs are shared between the University and the Hospital.

At the same time the clinic is a small central unit at the hospital to which patients from all departments of the hospital can be referred. I have two collegues each in half time positions, so the overall numbers of patients in the clinic are limited to 9 - 12 as noted in the contract with the hospital.

We are required to develop models of assessment and treatment, and to gradually document which clients can benefit from music therapy and how. In other words we are expected to prove that music therapy can support other treatments offered at the hospital and to prove that we can offer something which is not there already.

In Denmark it is not common to have music therapists in psychiatric hospitals or in district psychiatry. A normal team includes psychiatrists, psychologists, physiotherapists, occupational therapists, social workers, nurses and psychiatric nursing aids. There are no traditions for either music therapists or other creative arts therapists. There is a tradition that some occupational therapists or phsisiotherapists undertake some courses and do musical activities or painting
activities with the patients, but not as a specific treatment.

So to get a job in psychiatry as a music therapist someone has to persuade the head of the hospital to eliminate a position from another group of professionals, and if they decide to do so the trade union of this profession will fight the hospital at many levels. Even with this problem, today there are nine music therapists working as clinicians at psychiatric hospitals in Denmark. Four of those music therapists are part-time workers.

As it is so difficult to advocate the need for music therapy as an available treatment in hospital-based psychiatry, one of the first tasks we tried to solve at the clinic was to define as clearly as possible:

- what referral criteria are relevant for referring patients to music therapy?
- which client population (diagnoses) have the best prognosis to benefit from music therapy?
- what does music therapy offer which is not already covered by other professions?

The referral criteria were in our evaluating report (1998) listed as follows:

1. Ability to be co-operative (come to the therapy regularly and at the time agreed on)
2. Ability to formulate goals and purposes for the music therapy or be able to comprehend and accept the goals formulated by the therapist.
3. Potentials for insight (be able to reflect verbally or musically)
4. Ability to enter a therapeutic alliance or a wish to work with problems related to entering such an alliance
5. No risk of malign regression.

As many of our patients included schizophrenics, psychotics, and others with a weak ego function these criteria often had to be modified and to be related to the unique situation of each patient referred. My two former colleagues Britta Frederiksen and Charlotte Lindvang elaborated further on the topic of suitability for music therapy with the ego week patients in the Nordic Journal 1999, 8 (1). They concluded:

"By setting up criteria we face the paradox of offering help and at the same time having demands to the person applying for help. We face the question if suitability for music therapy should be evaluated on the basis of the patient’s resources or on the basis of the patient’s deficits. Often the evaluation will contain aspects of both. It is important to have an eye for those potentials each patient has. But it is necessary with a minimum of demand as well. However this minimum can be difficult to define.

When the therapist holds out her hand in order to meet the patient where he is, the patient must be able to grip and hold this hand somehow. Otherwise there will be no tangible meeting and no basis for psychotherapy. Sometimes patients, who cannot gain from a verbal psychotherapy, will be suitable for music therapy. And sometimes the case is that the patient does not have the capacity at the moment to profit from any kind of psychotherapy - nor music therapy. It is important to differentiate between these two groups. It is also worth mentioning that the patient who is evaluated as unable to profit from music therapy as a psychotherapeutic offer of treatment might be able to profit from other modalities in music therapy. The patient’s suitability is considered to depend also
on the therapist's capacity to be empathic, and to create a room of resonance for the patient. The interactive point of view demands that the therapist consider thoroughly her own motives to work with or refuse a certain patient. Issues of countertransference must be examined closely in the case where suitability is hard to evaluate."

So these thoughts somehow mirror the gap between proving which clients are suitable for music therapy (for the surroundings) and the reflections on which factors can in any way create a meeting point with the client as a basis for this evaluation of suitability. It is a phenomenon which concerns both the client and the therapist, and the way of using music.

For the hospital we have defined two main areas of patients where music therapy could be considered as a suitable treatment offer.

1. The first group of patients are a variety of neurotic patients, patients with personal disturbances, or patients with obsessive compulsive disorders, where patients have already been evaluated as suitable for verbal psychotehrapy but who might benefit more from music therapy if:

   - the patient is strongly overintellectualising
   - the patient has no or poor connection with emotions or wishes (anhedonic features)

2. The second group of patients are patients with a very weak egofunction or even psychotic patients who have been evaluated as not suitable for verbal psychotherapy as they are estimated to have no, or very poor potentials for psychodynamic insights.

In the last case music therapy has sometimes shown itself to be the key to break an isolation. Sometimes music therapy has brought the patient to a state of high motivation for developmental work and also to a basic state of gaining insight into himself/herself. The insight may take place only in the music at the beginning as described by my colleague Niels Hannibal. At the clinic we describe music therapy with this second group of patients ‘the very first step in psychotherapy’.

From clinical experiences with both patient groups we have clinical documentation that music therapy can supply verbal therapy treatment offers and we are starting to research this function of music therapy on different levels. For more than a year, we have examined the stability of appearance for the ego weak patients compared with patients from group 1. The difference in stability turned out to be so small, that we can reject the hypothesis that instability in presentation is a contraindication to being offered psychotherapeutic treatment. We have also made a questionnaire examination of patients who have finished their music therapy treatment. From all the patients in groups 1 and 2, 80% answer very positively that they have benefited from music therapy treatment, and also that the combination of music and words were experienced as effective. We have tried to define what is musical insight, and describe the importance of the presence of the therapist and of creating spaces for encounters inside and outside musical interactions. We are now starting to describe different levels of building up alliances with these patients.

I have documented music therapy as the very first step of psychotherapy through a case presentation in the book "Clinical Applications of Music Therapy in Psychiatry" (Wigram & De Backer 1999) and here I would like to document my reflections on encounters and dialogues through a case presentation with a patient from group one.
First I want to return to the hierarchy at the psychiatric hospital. There is a rather visible hierarchy between staff members belonging to the treatment level and staff members belonging to the nursing/activity level.

At the first level you find treatment offers of medication, verbal psychotherapy, music therapy and psychoeducation. The staff include psychiatrists, psychologists and music therapists.

At the next level you find activity and training staff members such as physiotherapists, occupational therapists and social workers. Finally, you find the daily framework for the patients on the ward - the nurses and psychiatric nurse aids, who also often have the role of being a contact person for one patient.

As music therapists who are placed in a central unit, we have to be very careful in cooperating with the nursing staff, and to be very sensitive and informative in our cooperation with them. On the other hand we have to be very clear in demanding that they have a responsibility in helping the weak clients to remember the dates for music therapy and that regular meetings are a precondition for treatment. Often they think of music therapy as an activity and it sometimes happens that they make another appointment for the patient at the time as music therapy. It is a hard work to build up the culture of knowledge that attending music therapy is as important as seeing a doctor f.inst or taking the medicin etc. But it is in progress.

Overall we work in a paradox:

- coming from a humanistic tradition believing that existential encounters are very important and valuable even if they only exist here and now
- and at the same time we are asked by the doctors if we can prove permanent outcome from the music therapy work.

That is why I would like here to both present some musical examples to illustrate musical encounters and dialogues from inside - the implicit perspective, but also share some inquiries I have made with the patients to try to get to know more about their perceptions of these encounters in an overall process - the explicit perspective.

I recognize myself as more of an analytical oriented music therapist than a Nordhoff/Robbins oriented music therapist. I took extra training sessions with Mary Priestley during and after my Herdecke Training Course (Personal sessions and Intertherapy) to dive deeper into this way of perceiving and understanding the process of music therapy. This means that I use both verbal and musical parts in my clinical work when possible and I often use playing rules to start off the improvisations. So I have grown up using the terms transference and countertransference, and I still think that of all the multiple definitions I have read in music therapy and psychology literature Mary Priestleys definitions and differentiation between c-countertransference and e-countertransference are the ones I can mostly be in resonance with.

She writes in her book "Essays of Analytical Music therapy" (1994):
"e-countertransference also called concordant identification are those psychological contents that arise in the therapist by reason of the empathy achieved with the patient and that really reflect and reproduce the patients psychological contents. The therapist`s total reponse to the patient`s needs. The resonance of the exterior to the interior - a plucked string instrument (the patient) whose music resonates on its sympathetic strings (the therapist)."
I have tried to understand the terms of countertransference by defining them as a listening attitude - as the phenomenon of listening and, I would also say, of expanded listening, is a basic tool of all music therapists.

I have been inspired to develop these terms from my work with schizophrenic patients where I experienced that my way of listening was vital to the possibility of creating an encounter.

I define the listening attitude as:

- a state of being very aware - a state of extreme preparation for resonating any possible signal or vibration coming from the patient at the same time as one should not invade the patient.
- to listen to the music of the patient and the feelings behind however fragmented or rudimentary the music might sound
- to simultaneously create a musical frame which resonates what I hear and feel from the patient`s music
- not trying to direct the music into any kind of recognisable form from outside which could raise the patient`s anxiety of once more being let down, left out, abused or betrayed.

The awareness of this listening attitude is to create a space where the patient may feel less isolated - giving the patient a chance to be met in the psychotic “unfocussed being” as an entry to break down the isolation.

This way of listening I also call a disciplined subjective way of being present in my way of listening and by this I understand something slightly different than authenticity. I mention that because I realise many music therapists and psychotherapists use the term authentic as a core condition for a therapist. I think what we mostly do in the role of being a therapist is to allow ourselves to be extra sensitively present in a very professional way, so that we sound authentic to the patient but still have a "third ear" out of the encounter (the inner supervisor). At the same time I think we cannot be professionally present if we don´t feel a basic human love towards the patients.

I have defined disciplined subjectivity as follows:
To be present as a subject and at the same time to be emphatically oscillating in and out of the client`s universe. It includes being at a very sensitive state of awareness in order that:

- the therapist can sense the psychic vibrations and emotions she is a part of and at the same time can be responsible to herself of not being overwhelmed.
- That the therapist takes care to be aware of, and take responsibility for, her own influence in the psychic space of which she is a part .
- That the therapist is continually searching for ways of understanding the process of which she is a part
- The therapist is aware of and negotiating with herself ehn, how and what to respond to the client in feelings and thoughts !!!!

So many aspects of awareness are active at the same time. This also include being present in dual levels of consciousness.

An art therapist colleague A.Robbins has described very clearly the dual levels of consciousness which I think most music therapists use in their interplay. He says:
"I try to be open to my patient while remaining fairly separate and clear, as I listen to the patient’s story (music). This openness can be described as a state of just being, or being very present. In a sense, I become one with the patient, though this should not be confused with a fusion state. I am being present in the presence of my patient, and in so doing I temporarily suspend my boundaries and let the full force of the patient enter my inside. Yet at the same time I am separating out my feelings and giving them shape and form. I am moving back and forward from a more holistic interactive stance to a more cognitive, separate one, a rhytme slowly develops between the patient and myself. I try to sense the flow and pattern of this rhytme. Do I have trouble I am either too removed or else too involved inside my patient’s emotional state. Sometimes I am unable to feel any rhytm, nor can I create a transitional space where we can meet. The transitional space becomes a meeting room where two minds join one another, engaged as well as finding their separatedness, creating for one another a field of forces. In this space we both strive to discover our presence, fueled by the energy that emanates from our mutual centres. This struggle ultimately creates forces of resonance, dissonance and the possibility of reshaping our energy."

(Robbins, A. 1998)
Form(ation)s of Encounters - Ways to Dialogues.

So as you may have noticed my main interest concerning the topic of formations of encounters - ways of dialogues concern:

- how the therapist is attuning herself to be present
- how to raise the therapist’s awareness of movements in being present in the therapeutic process
- how to use awareness (not control) in the musical interaction
- how to raise the therapist’s awareness of the relational potential of the client and the therapist

STILL ONE CAN NEVER PLAN FOR AN ENCOUNTER

In Adult psychiatry with schizophrenic, schizotypic patients I have primarily recognized the following modes of relational potentials in the context of: music therapist - music - patient.

1. The patient gives no premise for contact/The therapist has to accept and very gradually to find a port of entry
2. Confluence (Symbiosis, without borders)
3. The patient solely gives the premises for contact
4. Encounter/Meeting (Where both partners are aware of contact here and now)
5. Relationship over time (Alliance) where positions of contact can change along the way without breaking up the relationship. Both partners are aware of the meaning of the relationship.

In work with personal problems and other nonpsychotic problems I have recognised modes 2 to 4 of relational potentials

In the following case presentation I will document and refer to modes 2 to 4 of these potentials of relationship:

Case presentation: Patient H.
H is a male patient who is 43 years old. He is diagnosed as having a disturbed personality with strong anhedonic and obsessive features - very intellectualising in verbal contact with other people. H. has been tested by Wais, Luria and Rorschach tests before being referred to music therapy. H. is categorized as F.60.8 from ICD 10, (WHO, 1993).

We agreed during the pre-talk on the aim of therapy being: To try to develope the patient`s potentials to establish contact with himself and with others - especially woman. This aim of the work includes working on bounderies, and on problems in coping with authority.

Example 1. From the initial phase. (Download Soundfile, 693 kb)

H. has not been playing music before the start of therapy. In the very first session I asked him to choose an instrument. He chose the piano which I have noticed is very often the case with intellectualising patients. They consider the piano as a "grown up", challenging instrument. I asked him to strike a sound and listen to it and to let this sound lead him to the next sound, listen to it and so on. He started searching to express himself on an unknown instrument and he gradually followed my instructions. He played single sounds either in the lower or the upper part of the piano. The sounds were individual in the beginning - not interrelated and he created a fragmented soundpicture.

I listened to his music to sense how I could be a part of this picture and ,playing the second piano, I intuitively placed myself as a kind of centre in the picture - repeating one sound in a heart beat rhythm, but with varied dynamics in my way of playing as if coming closer and being more distant through the sound. I took a position but I couldn`t know for sure if is was meaningful to him. Gradually H played more related sounds - at one point as a melody with a strong drive in its rhythm and direction but constantly rushing back to a more fragmented way of playing the sounds. In some moments his sounds and my repeated sound created beautiful harmonies but I was unsure if he noticed my part of the music.

We played for about 15 minutes and, after the music finished, he sat at the piano for a couple of minutes without talking and then suddenly said: "I have no words." And after a long break he continues: "But I heard quite some melancholic moods there."

I considered these statements as very important for a person normally talking a lot and overintellectualising in his way of speaking. As I felt in rather close contact with H during some of the music playing I asked him afterwards if he had heard my part in the music. He said: hardly at all, but I had a sense of some kind of a centre somewhere which I came a little closer to in between and which I also moved away from. I also asked him if I had disturbed him - which he denied. He reflected that he probably needed a centerpoint from outside to ground himself and we decided that this role should be my part of the music over the next sessions.

This patient seemed not to be aware of moments of encounters in the session either from being part of the music or from listening to the recorded music afterwards what we did.

This case lasted for two years. After we had finished I asked a group of music therapy collegues working within psychiatry and a student group to listen to this example together with three other music examples from this same case. The other three examples are from the last session, the middle session and a randomised seession in between. I asked both groups to work out and tell me the chronological order of the examples (of which they were not informed before listening).
The group members ended up with different results. However, all members in both groups talked about being in doubt whether this example presented above was from the first session or from the last session in our case. Their views were that the harmonies we created together sounded rather intimate and that they thought there was sometimes a really close connection both between the patient’s sounds in his melodi formations but also in the chords.

In the student group they also spontaneously expressed two different reactions on the way the therapist was playing:
1. Calming/offering a space for searching for the patient
2. Provoking/a feeling of being rigidly hold - cannot get out of it.

The patient who has given me permission to use the material for all purposes which can be of any benefit to music therapy was invited to the clinic three years after the case had finished. He listened to five of the examples described here (all except nr 2). He was asked to define the level of meeting/being related in each of the examples by scoring on a list from 1 to 10, where 1 is no contact and 10 is very close contact. He scored this first example on a 9 (close contact), the same number as his scoring of the music example from our last session together. He was also asked to categorise the examples on the IAP (Improvisational Assessment profiles) created by K. Bruscia (87), the scale of autonomy. The categories of this scale include:

3. Resistor
4. Leader
5. Partner
6. Follower
7. Dependent.

In this first music example H placed himself as the leader and the therapist as the follower.

The leader on the scale is defined as: The one who comes up with most ideas and decides the direction of the improvisation. The follower on the scale is defined as: The one who gives most of the responsibility for the music to the leader.

Example 2 (session 14). (Download Soundfile, 768 kb)

I often experience that the initial phase and often as here the very first session mirrors a way to build up contact with the patient. In this case I found a position of being a centre, almost without the patient noticing. This dynamic developed in the next sessions and months. H simply asked me to play his center or his ground or his lifeline. He also each time told me which instruments he wanted me to play.

In example 2 H plays the piano, while the therapist uses the congas and the voice.

Here, H is more acting out in his music, playing loudly, chaotically and energetically on the piano. The pulse is a little unstable. He is alternating playing loud sounds and repeating clusters. I try to follow the dynamic and the energetic level on the drum and through my voice. At the same time I try hard to keep a stable pulse. At the end we meet shortly in a soft sound and slow tempo for
a few seconds but the patient immediately stop the music as if he burned his fingers. He tells me that this energetic way of playing reminds him of taking drugs which he did when he was younger. But here he doesn’t feel empty after playing. Taking drugs made him feel empty afterwards.

Generally in this phase from month two to six in our process he did a lot of acting out work and he gradually got at better contact to feelings of rage and sorrow. After six months he started dreaming again, which he had not been doing for years.

Example 3 (session 32). (Download Soundfile, 603 kb)

he brought one very important dream - among many others - to music therapy. He told me:
"I was running along - searching - climbing a fence of barbed wire and finding myself on a frozen water whole. Just under ice I saw a fossilized sea urchin, which I recognised as a part of myself."

I encouraged him to use his voice expressing this fossilized sea urchin and we improvised together for the first time with unaccompanied voices. During the improvisation I listened to him from a perspective of sharing with him the quality of this fossilized animal. Listened to him being in a very sensitive attitude. Our voices sounded very thin, insecure and icy. We both sounded very naked in the voice quality and gradually came into more audible sounds. The music is of a very fragile quality; a high pitch, pianissimo and an icy quality. Gradually both voices grew in sound volume and created more vibrations and sound waves, which can be understood as if the performers are becoming more and more present and related in the joint space of sound. In listening to and opening up to his inner feelings I felt almost over whelmed by insecurity, and tried to resonate his expressions as icy, fragile and insecure as they came out.

We were improvising standing side by side with closed eyes - sharing the atmosphere of extreme insecurity in the room. After this improvisation he himself was reminded of the fossilized sea urchin and he was very touched by the experience - and most important - he was able to show it to me.

In listening to this improvisation 4 ½ years later H also quoted a 9 on the scale of contact where 1 is no contact and 10 is very close contact.

On the autonomy scale he marked:
Patient: partner and follower
Therapist: Partner and leader

He dared surrender a little and he started a long process of melting the fossilized sea urchin.

This session with our first voice improvisation together opened up for another stream of energy than the aggressive stream he had been working on for half a year. He started to recognise himself as being a man with some powerful energy which he could accept better.

Example 4. (Session 42). (Download Soundfile, 690 kb)

This example illustrates that he now dared to explore deep sound colours with his voice and he was much more secure and playful. The improvisation was an expression of a black panther coming up several times in his dreams. It made him reflect more about the feminine and masculine side of himself.
Example 5 (session 48). (Download Soundfile, 319 kb)

At this state my feeling was that he was now trusting himself and his voice expression sufficiently to make solo voice improvisations with me listening to him. He agreed and the example demonstrates him improvising over a playing rule where he - with closed eyes - imagined being present in his private room inside his body and just around his body. He imagined allowing himself to shut out other people in his imagination and to stay to himself and express himself - even just be proud of himself.

This playing rule was repeated in the next week and gradually it was expanded to let him oscillate between being in this private room and shutting out other people (or at least shutting out his fantasies of other people’s judgements) and from there moving to a social room where he could interfere with me here and now and with other people in between the sessions. The important task at this point was to make him understand how important it was that he didn’t lose his perception of himself in the private room when he interfered with other people. Voice improvisation as expression of playing rules seemed to be very effective and very easy for him to cope with and to understand. It mirrored his state of being and being present either with himself or in encounters with others.

From session 48 I felt that I could gradually leave the position of being a servant who first took the role of a centerpoint - later the state of very sensitive awareness and then facilitator. More and more I could play my own music as it occurred inspired by the interplay with this specific patient.

Example 6. Session 57. (Download Soundfile, 2.4 mb)

The last example is an excerpt from our very last session and last improvisation together. In session 55, the patient decided to stop the therapy and we planned for two departure sessions. He claimed that he now felt like being ready to go out and exercise in real life. He also claimed that he felt much younger now, more vulnerable but also much more more integrated in his self-awareness.

In this last musical improvisation I felt free to play intuitively without supporting or challenging in any clinical way. I perceive the music as a dialogue in the way that we have a common feeling of pulse and of foreground and background. We both take parts in introducing new melodies and sound colours. We have a common wave-like rhythm and I felt like I could just as well have been improvising with a colleague.

So in this case coming to the phase of a real/equal dialogue also was the phase for closing the therapy. The patient allowed himself more and more to be aware in meeting me in the music, the process of development of this awareness started with our first voice improvisation together in session 38.

The patient also scored a 9 on the contact rating scale for the last session, and he noted:
Patient: partner, follower
Therapist: leader

He added in handwriting: "We were partners on the piano but not so much with our voices in the beginning of the music. At the end I think we landed on 10." ( on the contact rating scale).

For a patient with such a serious diagnosis I experienced these statements as very encouraging.
I would like to bring also an excerpt from a patient report he wrote for an article on music therapy for the medical journal MEDICUS three years after having finished music therapy treatment.

"More than three years have passed since the music (therapy) stopped. Things have happened. I feel like having partly changed and still part of me remains the same. But I have a clear feeling of being able to "fill up" myself much better than before the music therapy.

Earlier I often felt like a sad lonely and misunderstood "steppe woolf" sitting in a waiting room, and when being with other people I felt like the spion coming in from the coldness. I am still a "steppe woolf" but now a far more free, unpredictable, amused and acting one. Instead of being tacit and speculating I am now a woolf who enjoy howling with the others. I am much better in taking care of myself and I am not that scared of hurting other people. My former morning crisis - crisis which could last for the whole day - where I felt like a catastrophe was waiting just around the corner has almost disappeared. Even if the music therapy is officially ended I feel as if it is still working in me. All the experiments, sounds and motifs I created in the music I am now using in interaction with other people and this gives me a greater feeling of freedom - freedom understood like me having many more strings to play on - many more possibilities of handling different life situations. I still make sound improvisation with my voice just to sense how I feel like just now deep inside myself. This gives me a useful tool to loosen up for psychological knots and tensions coming up."

Summing Up.

I think it is very complex to describe or even to define phenomenons of form(ation)s of encounters and ways to dialogues in musical improvisations both in general but even harder in work with psychiatric patients.

For me it raises questions like:
Can we call it an encounter if this is not consciously perceived by both partners, the patient and the therapist.

Can we call it an encounter if the patient, like in this case does not perceive it in the her and now, but clearly perceives it 4 ½ years later?

Can encounters be described from solely analysing the musical material?

In my own way of coping with these questions I have emphasized means of description:

1. The state of prescence of the therapist in the music in the moment
Here demonstrated by defining the listening perspective and describing the therapist being centered and using an overall term "disciplined subjectivity" and by having transferred those phenomenons into the description of the music examples especially by stressing the function of the therapist in the interplay.

2. An analysis of the music from some kind of relational perspective
Here demonstrated by use of the homemade contact rating scale from 1 to 10 and by use of the
autonomy scale of the IAP. I have underpinned this perspective from descriptions of the dynamic in the interplay.

3. A feedback or report from the patient. Here demonstrated by quoting some of his sentences connected to the music, and by reporting his scorings by listening to the music 3 years after the therapy has ended, and by bringing excerpts of his report.

I think a variety of overall factors like: the phase in the therapy, the psychic presence of the patient, the therapists therapeutic presence, the sense of the music, the use of musical elements and the patients ability to formulate his/her experiences are important in collecting knowledge about formations of encounters and ways of dialogues. And I don´t think we can be sure of encounters being experienced by the patient from just analysing the musical elements.

But it is not very often we as clinicians have the possibility to collect all those different sorts of data.

List of literature:

- Pedersen, Inge Nygaard: (1999): "Musikterapi - et nyt behandlingsstilbud." (Music therapy - a new offer of treatment) IN : "Medicus" 6, 99 (the medical journal in the county of Aarhus.) The Doctors Council in the County of Aarhus. DK
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Music therapy research:
A review of references in the medical literature

David Aldridge, PhD
Chair of Qualitative Research in Medicine
University Witten Herdecke
Alfred Herrhausen Strasse 50,
58448 WITTEN, Germany
davida@uni-wh.de
Music therapy research: A review of references in the medical literature

David Aldridge

Music therapy is widely reported in the medical literature. There has been substantial progress in the establishment of research strategies for supporting clinical practice.

Introduction

Music therapy has risen to the challenge of research in recent years. Not only is there a tradition of quantitative research but qualitative research approaches have been also incorporated within the discipline as is necessary for an clinical approach that involves science and art (Aldridge 1996a; Dileo 1999; Pratt and Erdonmez-Grocke 1999; Pratt and Spintge 1996; Wigram, Saperston, and West 1995b).

See also music therapy world.net

Hospital based overviews

After the second world war music therapy was intensively developed in American hospitals. Since then some hospitals, particularly in mainland Europe, have incorporated music therapy within their practice carrying on a tradition of European hospital based research and practice.

The nursing profession has seen the value of music therapy, particularly in the United States of America, and championed its use as an important nursing intervention even when music therapists are not available. Indeed, it is a clinical nurse specialist has made an overview of fourteen articles on audioanalgesia (Bechler-Karsch 1993). She reports a confusing picture of changes related to heart rate but a clearer picture emerges on physiological parameters related to pain and anxiety and she concludes that music has no adverse effects on ill patients when used as an adjunctive non-invasive therapy.

Standley (Standley 1995; Standley 1986) has consistently reviewed the literature relating to music therapy applications in medical settings made a meta-analysis of the current findings from 55 studies utilizing 129 dependent variables (Standley 1995). Standley concludes (1195 p4) that the average therapeutic effect of music in medical treatment is almost one standard deviation greater than without music (.88). From these results she generalizes that women react more favorably to music than men, as do children compared with adults. While music is less effective for severe pain it is indicated for chronic pain. Live music administered by a music therapist has a greater effect than recorded music and the effect sizes vary according to the dependent measure being used, physiological measures being stronger than subjective assessment.
During the last 1990’s there has been a collection of writings related to the clinical application of music therapy, often from symposia (Pratt and Erdonmez-Grocke 1999; Pratt and Spintge 1996), and the development of research strategies suitable to clinical application (Aldridge 1996a; Wheeler 1995).

Psychiatry and Psychotherapy
The published work covering psychiatry has its basis in hospital treatment (Wigram, Saperston, and West 1995a).

In a study of chronic psychiatric patients who exhibited disruptive and violent behavior at meal times, the playing of taped music as a background stimulus with the intention of providing a relaxed atmosphere reduced that disruptive behavior (Courtright, Johnson, Baumgartner et al. 1990). Meschede and colleagues (Meschede, Bender, and Pfeiffer 1983) observed the behavior of a group of chronic psychiatric patients over eight weeks of active music making sessions and discovered that the subjective feelings of the patients had no correlation with the observations of the group leaders about the outward expression of those feelings.

Continental Europe has encouraged the use of music particularly in terms of individual and group psychotherapy for the encouragement of awakening the emotions of the patient, and in helping them cope with unconscious intrapsychic conflicts. This situation is not surprising given that the roots of psychoanalysis are middle European. Group psychotherapy has been used on an inpatient and outpatient basis.

Schizophrenia
Schizophrenia has been the subject of varying studies in applied music therapy (Aigen 1990; Glicksohn and Cohen 2000; Hadsell 1974; Pavlicevic and Trevarthen 1989; Pavlicevic, Trevarthen, and Duncan 1994; Tang, Yao, and Zheng 1994).

Within recent years researchers have attempted to understand the musical production of schizophrenic patients (Steinberg and Raith 1985a; Steinberg and Raith 1985b; Steinberg, Raith, Rossnagl et al. 1985) in terms of emotional response. The underlying reasoning in this work is (i) that to produce music depends upon the mastery of underlying feelings, and (ii) in psychiatric patient’s musical expression is negatively influenced by the disease. Steinberg and colleagues found that in the musical playing of endogenous-depressive patients there were weakened motoric qualities influencing stability and rhythmicity, while manic patients also exhibited difficulties in ending a phrase with falling intensity. Tempo appeared uninfluenced by depression, but was susceptible to the influence of medication. Schizophrenic patients exhibited changes in the dimensions of musical logic and order.

More recently Pavlicevic and Trevarthen (Pavlicevic and Trevarthen 1989) have compared the musical playing of 15 schizophrenic patients, 15 depressed patients and 15 clinically normal controls. Significant differences in musical interaction between therapist and patient were found between the groups on a self-developed scale to test musical interaction. This musical interaction scale was developed to assess the emotional contact between therapist.
and partner according to musical criteria based upon six levels of interaction ranging from no contact (Level 1) to established mutual contact (Level 6). A critical element of the musical contact is the establishment of a common musical pulse that is defined as a series of regular beats.

In the above study, schizophrenic patients appeared musically unresponsive and idiosyncratic in their playing which correlates with other studies of schizophrenia (Fraser, King, Thomas et al. 1986; Lindsay 1993). The depressed patients appeared to make fewer initiatives in the music although it was possible for the therapist to make contact with them. Controls were able to enter into a musical partnership with the therapist and take musical initiatives. The lack of reciprocity from the schizophrenic patients seemed to be the factor that prevented contact and thereby disturbed communication. However, this finding with individual patients is in contrast to the previously mentioned group studies that refer to ‘open’ communication within the group. The strength of the Pavlicevic paper is that it is firmly grounded in empirical data and, unlike many of the group therapy papers, gives clear evidence of how conclusions are reached.

The peculiarities of language which accompany some forms of the schizophrenia has led to the inevitable link between speech disorders and musical components of language and the processing of language and musical information. Fraser’s study (Fraser et al. 1986) suggested that the speech of schizophrenics had fewer well-formed sentences, often contained errors with many false starts and was simpler than the speech of controls which was fluent, error free and complex. Lindsay (Lindsay 1980) argues that social behavior is dependent upon social language skills of communication. Withdrawn patients speak with less spontaneous speech utterances, and their speech is improved by matching their utterances and building up dialogues from simple interactions to complex sequences; which is a feature of dialogic playing in improvised music therapy.

Adolescent psychiatry
Group music therapy is the principle music therapy approach to the treatment of adolescent problems. Friedman (Friedman and Glickman 1986) recommends the use of creative therapies in general for the treatment of drug abuse in adolescents as it encourages spontaneous activity, motivates the client’s response and fosters a culture of free expression.

Phillips (Phillips 1988), as psychotherapist and jazz fan, provides an overview of improvisation in psychotherapy and the way in which it relates to adolescent patients. He identifies four important qualities as bases which enable the therapist to improvise in clinical practice: (i) to have access to his or her past; (ii) to be able to focus attention solely on the present; (iii) to be comfortable enough to give up control over the outcome of the task to experiment during the session, and (iv) recognize the significance of accidental expression (p184). He relates this ability to improvise to the therapeutic task of treating adolescents who call upon a wide range of responses which relate to the past experience of the therapist.
and which may require quite novel solutions.

Culture
Most of the references to the use of music therapy in medicine are predominantly Western, although the use of music as a therapeutic medium is found in most cultures. Two papers (Benjamin 1983; Devisch and Vervaeck 1986) describe the use of music in African hospitals, both locating the use of music within a cultural context, and combining this music with drama and dance. As in other group therapy methods, music is used as a vehicle to reach those who are isolated and withdrawn and reintegrate them into social relationships.

In South Africa (Benjamin 1983) the group consists of about 100 female patients sitting in a circle directed by a doctor. Music, through increasing tempo in singing and dancing, is used as an activator for the psychodrama techniques of Moreno (Moreno 1946).

A Tunisian approach is far more radical in terms of psychiatry. Through ‘art group therapy’ (Devisch and Vervaeck 1986) utilizing dance, painting, therapy using clay, role play and singing, patients are encouraged to integrate personal experiences and emotions within a social context of relationships. The explanatory principle behind this work is that of ‘the door’ whereby fixed barriers between experiences are broken down, but the concept of threshold between experiences remains. In support of this integration family members of patients can be included in the singing and dancing to facilitate the patient returning to a family or wider social environment. For the individual patient it is argued that individual expression, when given the form of a work of art (to include singing and dancing), allows the person to experience themselves as something orderly and subjective; and, like a door, be able to opened or closed to others and participate in interaction. This ability to discriminate between activities is called by the authors (who are social anthropologists), “the liminal or threshold function of the body and the door” (p543). Such an approach attempts to establish a meaningful relationship between the inner rhythms of the body, outer rhythms of personal interaction and broader patterns of cultural activity.

The Arab tradition, which regards the body as the meeting place of psyche and soma, and locates psychiatric illness within social relationships, gives cultural support to the ideas practiced in such an institution. Culture is a source of meaning that does not only act through cognition, but also through personal interaction. The way in which people greet each other, listen to each other, and play with each other structures the meaning of that interaction and has a direct experience on the body. Similarly bodily experiences shape social contact. The act of kissing as a greeting, for example, has an external effect on relationship and an internal effect on the emotional experiences of the body. This symbolic reality is not restricted solely to cognitive activity. We can further infer that the playing of music, and encouraging a person to express themselves in an articulate form within a relationship, promotes experiences that integrate the person inwardly within themselves.
and outwardly with others independent from cognition.

Rehabilitation
Strategies for rehabilitating psychiatric patients using group and family approaches are not solely confined to African traditions (Barker and Brunk 1991; Glassman 1991; Longhofer and Floersch 1993) and music therapy has a broad base within the tradition of psychiatric and general rehabilitation (Aldridge 1993b; Pavlicevic et al. 1994; Pratt and Spintge 1996; Purdie and Baldwin 1995; Purdie, Hamilton, and Baldwin 1997).

Haag (Haag and Lucius 1984) discusses theories including psychosocial factors involved in the development of, and in coping with, disability. Psychological intervention approaches are set out, focussing on their particular relevance to rehabilitation. Music therapy is also recommended for the rehabilitation of patients who have difficulty in expressing their feelings and communicating with other.

Psychosomatics
Where both physical and mental processes overlap within medicine, i.e. the field of psychosomatics, then individual and group music therapy appears to play an important role.

Multiple sclerosis is a chronic neurological disease of unknown origin that can result in severe neuropsychological symptoms. Symptom-orientated medication or physiotherapy does not easily relieve difficulties of anxiety, resignation, isolation and failing self-esteem seen in this disease. Lengdobler and Kiessling (Lengdobler and Kiessling 1989) set out to treat in a clinic, over a two-year period, 225 patients with multiple sclerosis with group music therapy. Each treatment period lasted for 4 to 6 weeks. A further part of their work was to discover the musical parameters of the playing of such patients using methods which were based on active improvisation; group instrumental playing, singing, listening and free-painting to music. Unfortunately the size of the groups is not recorded, patient attendance at the groups was uncontrolled and the reports made by the patients were unstructured. Those reports were vague and have promoted clinicians to pursue more rigorous research (Magee 1998; O’Callaghan 1996; O’Callaghan and Turnbull 1987).

Elderly
The psychosocial rehabilitation of older persons is one of the main problems in health policy. About one quarter of the over 65-year-olds face psychic problems without receiving adequate treatment and rehabilitative care. Substantial deficits exist above all in the outpatient and non-residential service sector, and the development of ambulatory, community-based services as well as intensive support for existing self-help efforts are necessary. Music therapy has been suggested as a valuable part of a combined treatment policy for the elderly (Aldridge 2000).

Music and dementia in the elderly
The responsiveness of patients with Alzheimer’s disease to music is a remarkable phenomenon (Aldridge 1993a; Aldridge 1994; Aldridge 1995; Aldridge and Brandt 1991). While language deterioration is a feature of cognitive deficit, musical abilities appear to be preserved. Beatty
(Beatty, Zavadil, and Bailly 1988) describes a woman who had severe impairments in terms of aphasia, memory dysfunction and apraxia yet was able to sight read an unfamiliar song and perform on the xylophone which to her was an unconventional instrument. In a doctoral thesis Foster (Foster 1998) demonstrated an improvement in autobiographical memory in dementia sufferers compared to normal controls with an auditory background condition of music. He suggests that it is the arousal due to experiencing music that facilitates improved cognition and that the patient is dependent upon environmental cues.

Certainly the anecdotal evidence suggests that quality of life of Alzheimer’s patients is significantly improved with music therapy, accompanied by the overall social benefits of acceptance and sense of belonging gained by communicating with others. Prinsley (Prinsley 1986) recommends music therapy for geriatric care in that it reduces the individual prescription of tranquillizing medication, reduces the use of hypnotic on the hospital ward and helps overall rehabilitation. Music therapy is based on treatment objectives; the social goals of interaction co-operation; psychological goals of mood improvement and self-expression; intellectual goals of the stimulation of speech and organization of mental processes; and the physical goals of sensory stimulation and motor integration. Such approaches also emphasize the benefit of music programs for the professional carers and families of elderly patients.

There has been recent research related music and its influence upon patients suffering with various forms of dementia and particularly the influence of music therapy in the treatment of Alzheimer’s disease (Aldridge 2000).

Research approaches to new treatments
Until recently, psychotherapy and counseling techniques had rarely been used with people with dementia. However, the change in emphasis within dementia care towards a person-centered approach, and often non-pharmacological approach, has meant that there is a growing clinical interest in their use (Beck 1998; Bender and Cheston 1997; Bonder 1994; Cheston 1998; Johnson, Lahey, and Shore 1992; Richarz 1997). This has also meant an increase in studies using creative arts therapies (Kamar 1997; Mango 1992) and overviews of music therapy as a treatment approach to Alzheimer’s disease have already been written (Aldridge 2000; Brotons, Koger, and PickettCooper 1997; Brotons and Pickettcooper 1996; Smeijsters 1997). What music therapy offers is an improvement in communication skills for sufferer and spousal caregiver, and possibilities for managing the disruption and agitation ensuing in the later stages of disease.

Individuals with Alzheimer disease often experience depression, anger, and other psychological symptoms. Various forms of psychotherapy have been attempted with these individuals, including insight-oriented therapy and less verbal therapies such as music therapy and art therapy. Although there are few data-based outcome studies that support the effectiveness of these interventions, case studies and descriptive information suggest that
they can be helpful in alleviating negative emotions and minimizing problematic behaviors (Bonder 1994).

Although there is a developing clinical literature on intervention techniques drawn from all the main psychotherapeutic approaches, there has been little research into the effectiveness of this work and such research as does exist often uses methodologies that are inappropriate for such an early stage of clinical development. While some authors (Cheston 1998) argue that clinical research should adopt case study or single-case designs, some researchers are also planning group designs for evaluating new clinical developments. My argument is for a broad spectrum of research designs that will satisfy differing needs. We know from experience that music therapy brings benefits to sufferers and the challenge is to convert this knowledge into evidential studies.

Annenmiek Vink, (Aldridge 2000), focuses on the treatment of agitation in Alzheimer’s disease using music therapy and her current work is in the administration of a controlled study in Holland. The success of such a venture may have a profound effect upon the political acceptance of music therapy as a non-pharmacological treatment modality should the results be of significance. I am tentative about suggesting how strong the impact of such research trials will be as there is never any guarantee that such studies will be heeded. More importantly, if such a study discovers that a control musical condition is almost as effective as music therapy then there may be support for using “music” in treatment settings but not necessarily music therapists. Given that music therapists are a professional groups with their own pay scales then while the argument for using musical initiative may be strong, the argument for employing music specialists may be weak. Research, and its results, are rarely neutral in their effect.

However, a qualitative understanding of how musical playing changes also offers profound insights into the relief of suffering. We simply cannot restrain our endeavors to one particular form of understanding. Differing research approaches will inform one another and the challenge is for us to co-ordinate our approaches such that the knowledge gained is pooled and shared. It is to such an end that this book is aimed.

The patient and his caregivers in dementia care
The absence of definitive treatments for Alzheimer’s disease and related dementias, researchers in a variety of disciplines are developing psychosocial and behavioral intervention strategies to help patients and caregivers better manage and cope with the troublesome symptoms common in these conditions. These strategies include cognitive interventions, functional performance interventions, environmental interventions, integration of self-interventions, and pleasure-inducing interventions. Although we have seen that more research is needed to further develop these strategies and establish their best use, psychosocial and behavioral interventions hold great promise for improving the quality of life and well-being of dementia patients and their family caregivers (Beck 1998).
We know that people who are suffering do not suffer alone (Aldridge 1998; Aldridge 1999). It is in a primary
care setting where dementia is recognised, and early recognition is important for initiating treatment interventions before a person becomes permanently or semi-permanently institutionalized and to minimize disability (Larson 1998).

Recent research on care-giver stress focuses extensively on its predictors and health consequences, especially for family members of persons with dementia. Gwyther and Strulowitz (Gwyther and Strulowitz 1998) suggest four areas of care-giver stress research: caregiver health outcomes, differential impacts of social support, care giving for family members with dementia, and balancing work and care-giving responsibilities.

In a study by Harris (Harris 1998), in-depth interviews with 30 sons actively involved in caring for a parent with dementia elicit the understanding of a sons' caregiving experiences. Common themes that emerge from such narratives are a sense of duty, acceptance of the situation and having to take charge as well as issues regarding loss, a change in relationships with other brothers and sisters, the reversal of role from based on having to take charge and the necessity to develop coping strategies.

In another study of the psychological well-being of caregivers of demented elderly people (Pot, Deeg, and VanDyck 1997), three groups of caregivers were identified; those providing care for two years after baseline; those whose care-recipient died within the first year after baseline, and those whose care-recipient was institutionalized within the first year. All groups of caregivers showed a great amount of psychological distress compared to a general population sample, with an overall deterioration of psychological well-being. As the elderly patient declined, and the caregiving at home continued, then psychological distress increased. For caregivers whose demented care-recipient had died or was institutionalized in the first year after baseline then there was no deterioration. There is, then, a high level of psychological distress and deterioration in psychological well-being among informal caregivers of dementia patients and we may have to reconsider the personal and social costs of demented older people live on their own as long as possible if we are not able to release adequate resources to support the caregivers.

Part of this support will include sharing information and developing methods of counseling appropriate to caregivers. Increasing public awareness, coupled with the wider availability of drug therapies for some dementing conditions, means that carers are often informed of the diagnosis of dementia. However it is unclear how much sufferers themselves are told about their diagnoses. In a study of how sufferers of dementia were given diagnostic information of 71 carers recruited through old age psychiatry services in East Anglia, half of the sufferers had learned their diagnosis, more from their carers than their doctors (Heal and Husband 1998). The age of the sufferer was found to be related to whether or not doctors told them their diagnosis, which supports a suspicion that there is a prejudice amongst doctors regarding the elderly and about what they can understand. Only 21% of carers were given an opportunity to discuss the issues...
involved and younger carers were significantly more likely to feel that such an opportunity would have been useful. Most of the carers who had informed the sufferer said that the sufferer had wanted to know, or needed a meaningful explanation for their difficulties, rather than giving more practical legal or financial reasons. Carers who had not disclosed feared that diagnostic information would cause too much distress, or that the sufferers' cognitive impairments were too great an obstacle. Emotional context and ability

As the course of degenerative disease progresses there is a decline in the ability to comprehend and express emotion that is linked with mental impairment (Benke, Bosch, and Andree 1998). The creative arts therapies have based some of their interventions on the possibility for promoting emotional expression and retaining expressive abilities.

Depression

Depression is a common disorder in the elderly (Forsell, Jorm, and Winblad 1998). The rate of treatment of depression in the very elderly is low, exaggerated amongst dementia sufferers, and the course is chronic or relapsing in almost half of the cases. The interface between depression and dementia is complex and has been studied primarily in Alzheimer's disease (Aldridge 1993b) where depressive depression may be a risk factor for the expression of Alzheimer's disease in later life (Raskind 1998). A contributory factor to this depression is the patients' perceptions of their own deficits, although these may be ill-founded (Tierney, Szalai, Snow et al. 1996). Emotional context is an important factor and this will be linked to the way in which the patient sees his or her current life situation and an understanding of what life holds in the near-future.

Hearing impairment

If depression is a confounding factor in recognizing cognitive degeneration, then hearing impairment is another contributory factor. Central auditory test abnormalities may predict the onset of clinical dementia or cognitive decline. Hearing loss significantly lowered performance on the verbal parts of the Mini-Mental State Examination, a standard test for the presence of dementia (Gates, Cobb, Linn et al. 1996). Central auditory dysfunction precedes senile dementia in a significant number of cases and may be an early marker for senile dementia. Gates et al. recommend that hearing tests should be included in the evaluation of persons older than 60 years and in those suspected of having cognitive dysfunction. If this is so then we may have to include this consideration in designs of research studies of music therapy as maybe the patients themselves are not actually hearing what is being played but responding to social contact and gesture. However, encouraging musical participation may foster residual hearing abilities and those abilities that the tests cannot measure. Returning to the developmentally-challenged children, where hearing disability was ever present, it was the joint attention involved in making music that brought about an improvement in listening that appeared as an improvement in hearing. This is perhaps a feature of active music therapy that needs to be further investigated.
What happens in treating dementia patients with music therapy
Most music therapists have concentrated on the pragmatic effects of music therapy. As we will see, both practitioners and researchers alike are concerned with demonstrating the benefits of music therapy for dementia sufferers. However, how music therapy actually achieves its effects is relatively unresearched.

My hypothesis is that music offers an alternative form for structuring time that fails in working memory. Just as developmentally delayed children achieve a working memory that enhances their cognitive ability, then the reverse process occurs in dementia sufferers.

While several components of working memory may be affected, not all aspects of the central executive mechanism are necessarily influenced (Collette, VanderLinden, Bechet et al. 1998). White and Murphy (White and Murphy 1998) suggest that tone perception remains intact, but there is a progressive decline in working memory for auditory non-verbal information with advancing Alzheimer’s disease. A similar decline was also noted on a task assessing working memory for auditory presented verbal information. This ties in with what we know about hearing impairment and again encourages a test of hearing capabilities before music therapy is used as a treatment modality but also suggests that music therapy may promote improved hearing.

Temporal coherence
I argue earlier that music therapy is indicated because it offers an external sense of temporal coherence that is failing in the patient. Ellis (Ellis 1996) reports on the linguistic features and patterns of coherence in the discourse of mild and advanced Alzheimer's patients. As the disease progresses, the discourse of Alzheimer's patients becomes pre-grammatical in that it is vocabulary driven and reliant on meaning-based features of discourse rather than grammatically based features. Temporal coherence fails. Knott, Patterson, and Hodges (Knott, Patterson, and Hodges 1997), considering the short-term memory performance of patients with semantic dementia, suggest that impaired semantic processing reduces the "glue" or "binding" that helps to maintain a structured sequence of phonemes in short-term memory. We may speculate that this temporal coherence, the metaphoric glue or binding, is replaced by musical form. As we know, some songs stick to our memories.

Not loss of semantic memory
Repetition ability depends in part on semantic memory remaining intact. If the conceptual contents of semantic memory are lost as a function of Alzheimer's disease, meaningfulness of stimuli should have progressively less effect on the ability to repeat as the disease worsens. A study by Bayles et al (Bayles, Tonoeda, and Rein 1996) was designed to evaluate the effects of meaningfulness and length of phrasal stimuli on repetition ability in mild and moderate of Alzheimer's disease patients and normal elderly subjects. Fifty-seven Alzheimer's disease patients and 52 normal subjects were given six- and nine-syllable phrases that were meaningful, improbable in meaning, or meaningless. Cross-sectional and longitudinal data analyses were conducted and results failed to confirm a performance pattern.
consistent with a semantic memory loss theory.

Several lines of evidence suggest that in Alzheimer's disease there is a progressive degradation of the hierarchical organization of semantic memory. When clustering and switching on phonemic and semantic fluency tasks were correlated with the numbers of correct words generated on both fluency tests, but the contribution of clustering was greater on the semantic task. Patients with Alzheimer's disease generated fewer correct words and made fewer switches than controls on both fluency tests. The average size of their semantic clusters was smaller and the contribution of clustering to word generation was less than for controls. Severity of dementia was correlated with the numbers of correct words and switches, but not with cluster size. The structure of semantic memory in Alzheimer's disease is probably degraded but there is no evidence that this process is progressive. Instead, progressive worsening of verbal fluency in Alzheimer's disease seems to be associated with the deterioration of mechanisms that govern initiation of search for appropriate subcategories (Beatty, Testa, English et al. 1997). This pattern can be interpreted as reflecting significantly impaired procedural routines in Alzheimer's disease, with relative sparing of the structure of semantic memory (Chenery 1996). No loss of source memory

A source memory task, using everyday objects in actions performed by either the participant or the experimenter, was given to probable Alzheimer's disease and elderly normal individuals. When the overall recognition performance of the two groups was made equivalent by increasing the test delay intervals for the control group, both groups of participants showed similar patterns of correct and incorrect responses. Moreover, both groups showed evidence of a generation effect and of an advantage for items repeated at study. The findings of this study suggest that, for a given level of event memory, memory for the source of the events is comparable between elderly normal and individuals with Alzheimer's disease (Brustrom and Ober 1996).

Contextual cues

Two experiments examined whether impairments in recognition memory in early stage Alzheimer's disease were due to deficits in encoding contextual information (Rickert, Duke, Putzke et al. 1998). Normal elderly and patients diagnosed with mild stage Alzheimer's disease learned one of two tasks. In an initial experiment, correct recognition memory required participants to remember not only what items they had experienced on a given trial but also when they had experienced them. A second experiment required that participants remembered only what they had seen, not when they had seen it. Large recognition memory differences were found between the Alzheimer's disease and the normal elderly groups in the experiment where time tagging was crucial for successful performance. In the second experiment where the only requisite for successful recognition was remembering what one had experienced, memory of the temporal record was not necessary for successful performance. In this instance, recognition memory for the both groups was identical. Memory deficits found in early stage Alzheimer's disease may be partly due
to impaired processing of contextual cues that provide crucial information about when events occur.

Foster (Foster 1998) carried out a series of studies of background auditory conditions that provided such a context, and their influence upon autobiographical memory. While the use of background music has no effect on word-list recall in the normal elderly, there is a constant beneficial effect of music for autobiographical memory for patients with Alzheimer's disease. This music did not have to be familiar to the sufferer, nor did it reduce anxiety. The effect of music is stronger in cognitively impaired participants thus promoting another reason for using music-based interventions in treatment initiatives. Foster, like Aldridge (Aldridge 1993c), argues for the use of music in assessment procedures.

As part of a program of studies investigating memory for everyday tasks, Rusted et al (Rusted, Marsh, Bledski et al. 1997) examined the potential of auditory and olfactory sensory cues to improve free recall of an action event (cooking an omelet) by individuals with dementia of the Alzheimer's type. Both healthy elderly and volunteers with Alzheimer's disease recalled more of the individual actions which comprised the event when they listened, prior to recall, to a tape of sounds associated with the event. Olfactory cues that accompanied auditory cues did not produce additional benefits over auditory cues alone. The pattern of recall suggests that the auditory cues improved recall of the whole event, and were not merely increasing recall of the specific actions associated with the sound cues. Individuals with Alzheimer's disease continue to encode experiences using a combination of senses, and that they can subsequently use this sensory information to aid memory. These findings have practical implications for accessing residual memory for a wide range of therapeutic activities using the creative arts that emphasize sensory abilities.

**Functional plasticity**

Conscious recall of past events that have specific temporal and spatial contexts, termed episodic memory, is mediated by a system of interrelated brain regions. In Alzheimer's disease this system breaks down, resulting in an inability to recall events from the immediate past. Using brain scanning techniques of cerebral blood flow, Becker, Mintun, Aleva et al. (Becker, Mintun, Aleva et al. 1996) demonstrate that Alzheimer's disease patients show a greater activation of regions of the cerebral cortex normally involved in auditory-verbal memory, as well as activation of cortical areas not activated by normal elderly subjects. These results provide clear evidence of functional plasticity in the brain of sufferers, even if those changes do not result in normal memory function, and provide insights into the mechanisms by which the brain attempts to compensate for neurodegeneration. Similarly, it has been demonstrated that Alzheimer's disease can effectively learn and retain a motor skill for at least 1 month (Dick, Nielson, Beth et al. 1995).

Both anterograde and retrograde procedural memory appear to be spared in Alzheimer's disease (Crystal, Grober, and Masur 1989). An 82 year old musician with Alzheimer's disease showed a preserved ability to play previously learned piano compositions from memory while
being unable to identify the composer or titles of each work. He also showed a preserved ability to learn the new skill of mirror reading while being unable to recall or recognize new information.

Communication

Characteristic features of communication breakdown and repair among individuals with dementia of the Alzheimer's type and their caregivers have been described recently (Orange, VanGennep, Miller et al. 1998). The nature of communication breakdown, how it is signaled, how it is repaired, and the outcome of the repair process appear to be disease stage-dependent. Couples in the early and middle stage of the disease achieve success in resolving communication breakdowns despite declining cognitive, linguistic and conversation abilities of the individuals with the disease. This has important implications for understanding the influence of the progression of Alzheimer's disease on conversational performance and for advancing the development of communication enhancement education and training programs for spousal caregivers of individuals with Alzheimer's disease.

Music therapy will have an important role to play here as the ground of communication, as we have seen, is inherently musical. Dementia sufferers appear to be open to musical stimuli and responsive to music-making, thus implementation of musical elements in facilitating communication and expression can be enhanced as the disease progresses. If music enhances communicative abilities -indeed, is the fundamental of communication - and spousal caregivers are important in managing the progress of the disease, then have to return to the idea that it is the caregivers who will benefit from music therapy.

Musical hallucinations

Hallucinations may occur in any of our senses, and auditory hallucinations take various forms; as voices, cries, noises, or rarely, music. However, the appearance of musical hallucinations, often in elderly patients, has generated interest in the medical literature (Berrios 1990; Brasic 1998; Mahowald, Woods, and Schenck 1998; Wengel, Burke, and Holemon 1989). When such hallucinations do occur they are described as highly organized vocal or instrumental music. In contrast, tinnitus is characterized by unformed sounds or noises that may possess musical qualities (Wengel et al. 1989).

The case histories of patients with musical hallucinations suggest an underlying psychiatric disorder (Aizenberg, Schwartz, and Modai 1986; Wengel et al. 1989); which may be exacerbated by dementing illness occurring with brain deterioration (Gilchrist and Kalucy 1983), or that patients with musical hallucinations and hearing loss become anxious and depressed (Fenton and McRae 1989). Fenton challenges the association of psychosis and previous mental illness, preferring an explanation that relies upon the degeneration of the aural end-organ whereby sensory input, which suppresses much non-essential information, fails to inhibit information from other perception-bearing circuits. Other investigators (Gilchrist and Kalucy 1983) argue for a central brain dysfunction as evidenced by measures of brain function. In a sample of 46 subjects experiencing
musical hallucinations were far more common in females; age, deafness, and brain disease affecting the non-dominant hemisphere played an important role in the development of hallucinations; and psychiatric illness and personality factors were found to be unimportant (Wengel et al. 1989).

For these patients the application of music therapy to raise the ambient noise level, to organize aural sensory input by giving it a musical sense and counter sensory deprivation, and to stimulate and motivate the patient seems a reasonable approach.

Music therapy, heart rate and respiration
The effect of music on the heart and blood pressure has been a favorite theme throughout history. In an early edition of the medical journal “Lancet” (Vincent and Thompson 1929) an attempt was made to discover the influence of listening to gramophone, and radio, music on blood pressure. The effects of music were influenced by how much the subjects appreciated music. Differing groups of musical competence responded in relation to volume, melody, rhythm, pitch and type of music. Interest in the music was an important factor influencing response. Melody produced the most marked effect in the musical group. Volume produced the most apparent effect in the moderately musical group. In general, listening to music was accompanied by a slight rise in blood pressure in the listener.

If music produces physiological and psychological effects, in healthy persons as listeners then it may be assumed that persons with various diseases respond to music in specific ways. A particular hypothesis, which is yet to be substantiated empirically, is that people with known diseases respond to music in a way that is mediated by that disease. Hence, we might find that the musical parameters of improvised playing are restricted by disease. Also, in terms of music therapy, if music is known to influence a physiological parameter such as heart rate or blood pressure, then maybe music can be used therapeutically for patients who have problems with heart disease or hypertension.

Bason (Bason and Celler 1972) found that the human heart rate could be varied over a certain range by entrainment of the sinus rhythm with external auditory stimulus which presumably acted through the nervous control mechanisms, and resulted from a neural coupling into the cardiac centers of the brain. An audible click was played to the subject at a precise time in the cardiac cycle. When it came within a critical range then the heart rate could be increased or decreased up to 12% over a period of time up to 3 minutes. Fluctuations caused by breathing remained, but these tended to be less when the heart was entrained with the audible stimulus. When the click was not within the time range of the cardiac cycle then no influence could be made. Bason’s paper is important for supporting the proposition often made by music therapists that meeting the tempo of the patient influences their musical playing and is the initial key to therapeutic change.

An extension of this premise, that musical rhythm is a pacemaker, was investigated by Haas and her colleagues (Haas, Distenfeld, and
Axen 1986) in terms of the effects of perceived rhythm on respiratory pattern, a pattern that serves both metabolic and behavioral functions. Metabolic respiratory pathways are located in the reticular formation of the lower pons and medulla, whereas the behavioral respiratory pathways are located mainly in the limbic forebrain structures that lead to vocalization and complex behavior. There appear to be both hypothalamic and spinal pattern generators capable of synchronizing this respiratory and locomotor activity. Therefore, Haas hypothesized that an external rhythmical musical activity, in this case listening to taped music, would have an influence on respiratory pattern while keeping metabolic changes and afferent stimuli (i.e. no gross motor movements) to a minimum.

Twenty subjects were involved in this experiment, four of whom were experienced musicians and practicing musicians, six had formal musical training but no longer played a musical instrument and the remaining ten had no musical training. Respiratory data including respiration frequency and airflow volume was collected alongside heart rate and end-tidal CO2. Subjects listened to a metronome set at 60b.p.m. and tapped to that beat on a microphone after a baseline period. The subjects were then randomly presented with four musical excerpts and a period of silence with which they tapped along to. There were no appreciable changes in heart rate during the experiment, but there was an appreciable change in respiratory frequency and a significant decrease in the coefficient of variation for all respiratory parameters during the finger tapping. For non-musically trained subjects there was little coordination between breathing and musical rhythm, while for trained musicians there was a coupling of breathing and rhythm. That singers have more efficient pulmonary strategies than non-trained musicians, even when talking, is supported elsewhere in the literature (Formby, Thomas, and Halsey 1989).

Auditory cues, then, appear to be important in the synchronization of respiration and other motor activity. It is this aspect of organization of behavioral events that appears to be the important aspect of music and central to music therapy (Aldridge 2000).

Coronary care
Several authors have investigated this relationship in the setting of hospital care (Aldridge 1993b; Bonny 1983; Davis-Rollans and Cunningham 1987; Elliott 1994; Fitzsimmons, Shively, and Verderber 1991; Guzzetta 1989; Philip 1989; Zimmerman, Pierson, and Marker 1988) often with the intent of reducing anxiety in chronically ill patients (Gross and Swartz 1982; Standley 1986), for treating anxiety in general (Robb 2000), or specifically in musicians (Brodsky and Sloboda 1997).

A hospital situation that is fraught with anxiety for the patient is the intensive care unit. For patients after a heart attack, where heart rhythms are potentially unstable, the setting of coronary care is itself anxiety provoking which recursively influences the physiological and psychological reactions of the patient. In these situations several authors, in varying hospital intensive care or coronary care clinics, have assessed the use of tape recorded music delivered through headphones as an
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anxiolytic with the intention of reducing stress (Updike 1990). Bonny (Bonny 1983) has suggested a series of musical selections for tape recordings which can be chosen for their sedative effects and according to other mood criteria, associative imagery and relaxation potential (Bonny 1978); none of which have been empirically confirmed; although Updike (Updike 1990), in an observational study, confirms Bonny’s impression that there is a decreased systolic blood pressure, and a beneficial mood change from anxiety to relaxed calm, when sedative music is played.

Rider (Rider 1985a; Rider 1985b) proposed that disease related stress was caused by the desynchronization of circadian oscillators and that listening to sedative music, with a guided imagery induction, would promote the entrainment of circadian rhythms as expressed in temperature and corticosteroid levels of nursing staff. This study found no conclusive results, mainly because there was no control group and the study design was confused highlighting the essential difference between music when applied as a music therapy discipline, and music as an adjunct to psychotherapy or biofeedback.

Davis-Rollans (Davis-Rollans and Cunningham 1987) describes the use of a 37-minute tape recording of selected classical music * on the heart rate and rhythm of coronary care unit patients. Twelve of the patients had had heart attacks and another twelve had a chronic heart condition. Patients were exposed to two randomly varied 42-minute periods of continuous monitoring; one period with music delivered through headphones, the other control period was without music and contained background noise of the unit as heard through silent headphones. Eight patients reported a significant change to a happier emotional state after listening to the music (a result replicated by Updike (Updike 1990)), although there were no significant changes in specific physiological variables during the music periods. A change in mood, however, which relieves depression is believed to be beneficial to the overall status of coronary care patients (Cassem and Hackett 1971).

Bolwerk (Bolwerk 1990) set out to relieve the state anxiety of patients in a myocardial infarction ward using recorded classical music **. Forty adults were randomly assigned to two equal groups; one of which listened to relaxing music during the first four days of hospitalization, the other received no music. There was no controlled “silent condition”. While there was a significant reduction in state anxiety in the treatment group, state anxiety was also reduced in the control group. The reasons for this overall reduction in anxiety may have been that after four days the situation had become less acute, the situation was not so strange for the patient, and by then a diagnosis had been confirmed.

State anxiety is an individual’s anxiety at a particular state in time, as opposed to trait anxiety that is an overall prevailing condition of anxiety unbounded by time and determined by personality. The relationship

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* Beethoven Symphony Nr.6 (first movement); Mozart, Eine kleine Nachtmusik (first and fourth movements) and Smetana, The Moldau.

** Bach, Largo; Beethoven, Largo; Debussy, Prelude to the Afternoon of a Faun.
between stress and anxiety is that stimulus conditions, or stressors, produce anxiety reactions; i.e. the state of anxiety. Anxiety as a state is characterized by subjective feelings of tension, worry and nervousness which are accompanied by physiological changes of heart rate, blood pressure, myocardial oxygen consumption, lethal cardiac dysrhythmias and reductions in peripheral and renal perfusion. Admission to the coronary care unit is itself a stressor, and the environment produces further stress, therefore the importance for managing state anxiety. 

The purpose of a study by Guzzetta (Guzzetta 1989) was to determine whether relaxation and music therapy were effective in reducing stress in patients admitted to a coronary care unit with the presumptive diagnosis of acute myocardial infarction. In this experimental study, 80 patients were randomly assigned to a relaxation, music therapy, or control group. The relaxation and music therapy groups participated in three sessions over a two-day period. Music therapy was comprised of a relaxation induction and listening to a 20 minute musical cassette tape selected from three alternative musical styles; soothing classical music, soothing popular music and non-traditional music (defined as “compositions having no vocalization or meter, periods of silence and an asymmetric rhythm” (p611). Stress was evaluated by apical heart rates, peripheral temperatures, cardiac complications, and qualitative patient evaluative data. Data analysis revealed that lowering apical heart rates and raising peripheral temperatures were more successful in the relaxation and music therapy groups than in the control group. The incidence of cardiac complications was found to be lower in the intervention groups, and most intervention subjects believed that such therapy was helpful. Both relaxation and music therapy were found to be effective modalities of reducing stress in these patients, and music listening was more effective than relaxation alone. Furthermore, apical heart rates were lowered in response to music over a series of sessions thus supporting the argument that the assessment of music therapy on physiological parameters is dependent upon adaptation over time. Further research strategies may wish to make longitudinal studies of the influence of music on physiological parameters.

This positive finding above was in contrast to Zimmerman (Zimmerman et al. 1988) who failed to find an influence of music on heart rate, peripheral temperature, blood pressure or anxiety score. However, Zimmerman’s study only allowed for one intervention of music. In this experimental study the authors examined the effects of listening to relaxation-type music on self-reported anxiety and on selected physiologic indices of relaxation in patients with suspected myocardial infarction. Seventy-five patients were randomly assigned to one of two experimental groups, one listening to taped music and the other to “white noise” °

° “White noise” or “synthetic silence” is an attempt to block out environmental noise. In this case it was a tape recording of sea sounds, which themselves were rhythmic.


Zimmerman, L. (1989) Reply to a letter asking what "white noise" was. 18, 3, 322.
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through headphones, or to a control group. The Spielberger State Anxiety Inventory (Spielberger 1983) was administered before and after each testing session, and blood pressure, heart rate, and digital skin temperature were measured at baseline and at 10-minute intervals for the 30-minute session. There was no significant difference among the three groups for state anxiety scores or physiologic parameters. Because no differences were found, analyses were conducted of the groups combined. Significant improvement in all of the physiologic parameters was found to have occurred. This finding reinforces the benefit of rest and careful monitoring of patients in the coronary care unit, but adds little to the understanding of music interventions. Time to listen, separated from the surrounding influence of the hospital unit by the use of headphones, may itself be an important intervention. Although Rider (Rider 1985a) did not reach this preceding conclusion; he found that perceived pain was reduced in a hospital situation in response to classical music delivered through headphones, it could be concluded from his work that isolation from environmental sounds, canceling out external noise, has a positive benefit for the patient regardless of inner content, i.e. music, relaxation induction or silence.

Given that Bason’s study (Bason and Celler 1972) could influence heart rate by matching the heart rate of the patient, then we must conclude that studies of the influence of music on heart rate must match the music to the individual patient. This also makes psychological sense as different people have varied reactions to the same music. Furthermore, improvised music playing which takes meeting the tempo of the patient as one of its main principles may have an impact other than the passive listening to music. In addition, the work of Haas (Haas et al. 1986) mentioned above showed that listening, coupled with tapping, synchronizes respiration pattern with musical rhythm, further emphasizing that active music playing can be used to influence physiological parameters and that this synchronization can be learned. Thaut (Thaut 1985) also found that children with gross motor dysfunction performed significantly better motor rhythm accuracy when aided by auditory rhythm and rhythmic speech.

Gustorff has successfully used music therapy in the treatment of coma patients in the context of intensive care (Aldridge, Gustorff, and Hannich 1990). This work has also been extended to persistent vegetative state where patients, seemingly unaware of their environment, begin to respond to the human singing voice (Aldridge 1991; Ansdell 1995; Gustorff 1990).

Anesthesia

The ability of music to induce calm and well-being has been used in general anesthesia. Patients express their pleasure at awakening to music in the operating suite (Bonny and McCarron 1984) where music was played openly at first, and then through earphones during the operation. In a study by Lehmann (Lehmann, Horrichs, and Hoeckle 1985) patients undergoing elective orthopedic or lower abdominal surgery were given either placebo infusion (0.9% NaCl) instead of tramadol in a randomized and double-
blind manner in order to evaluate tramadol efficacy as one component of balanced anesthesia. Post-operative analgesic requirement and awareness of intra-operative events (tape recorder music offered via earphones) were further used to assess tramadol effects. Although anesthesia proved to be quite comparable in both groups striking differences between the two groups were shown with respect to intra-operative awareness: while patients receiving placebo proved to be amnesic, 65% of tramadol patients were aware of intra-operative music. The ability to hear music during an operation is also reported by Bonny (Bonny and McCarron 1984).

**Cancer therapy, pain management and hospice care**

Cancer and chronic pain care require complex co-ordinated resources that are medical, psychological, social and communal. Hospice care in the United States and England has attempted to meet this need for palliative and supportive services that provide physical, psychological and spiritual care for dying persons and their families. Such a service is based upon an interdisciplinary team of health care professionals and volunteers, which often involves outpatient and inpatient care.

In the Supportive Care Program of the Pain Service to the Neurology Department of Sloan-Kettering Cancer Center, New York, a music therapist is part of that supportive team along with a psychiatrist, nurse-clinician, neuro-oncologist, chaplain and social worker (Bailey 1984; Coyle 1987). Music therapy is used to promote relaxation, to reduce anxiety, to supplement other pain control methods and to enhance communication between patient and family (Bailey 1983; Bailey 1984). As depression is a common feature of the patients dealt within this program, then music therapy is hypothetically an influence on this parameter and in enhancing quality of life. Although quality of life has assumed a position of importance in cancer care in recent years and music therapy, along with other art therapies, is thought to be important, the evidence for this belief is largely anecdotal and unstructured. Bailey (Bailey 1983) discovered a significant improvement in mood for the better when playing live music to cancer patients as opposed to playing taped music which she attributes to the human element being involved. Gudrun Aldridge (Aldridge 1996b), in a single case study, emphasizes the benefits of expression facilitated by playing music for the post-operative care of a woman after mastectomy.

A better researched phenomenon is the use of music in the control of chronic cancer pain, although such studies abdicate the human element of live performance in favor of tape recorded interventions.

In addition to reducing pain, particularly in pain clinics, music as relaxation and distraction has been tried during chemotherapy to bring overall relief (Kerkvliet 1990), and to reduce nausea and vomiting (Frank 1985). Using taped music and guided imagery in combination with pharmacological antiemetics, Frank (Frank 1985) found that state anxiety was significantly reduced resulting in a perceived degree of reduced vomiting, although the nausea remained the same. As this study was not controlled the reduced anxiety...
may have been a result of the natural fall in anxiety levels when chemotherapy treatment ended. However, the study consisted of patients who had previously experienced chemotherapy and were conditioned to experience nausea or vomiting in conjunction with it. That the subjects of the study felt relief was seen as an encouraging sign in the use of music therapy as a treatment modality.

There is a rapidly developing literature related to working with children with cancer (Aldridge 1999; Fagen 1982; Standley and Hanser 1995) that also focuses on specific issues like the management of pediatric pain (Frager 1997; Loewy 1997), hospitalization (Froehlich 1996) special needs groups (McCauley 1996) and the use of songs (Aasgaard 1994; O’Callaghan 1996).

Some music therapists work in situations with adult patients (Bunt 1995), or clients, who are living with challenge of the Human Immune-deficiency Virus (Aldridge 1993a; Aldridge 1999; Aldridge 1995; Aldridge and Aldridge 1999; Hartley 1994; Schnürer, Aldridge, Altmaier et al. 1995). There is a pioneering literature in this field of the work that has been developed by Colin Lee(Lee 1995; Lee 1996) and Ken Bruscia (Bruscia 1991; Bruscia 1995) and these two chapters demonstrate how other therapists have also been advancing the use of music therapy to meet this challenge.

**Neurological problems**

In many cases neurological diseases become traumatic because of their abrupt appearance resulting in physical and/or mental impairment (Jochims 1990). Music appears to be a key in the recovery of former capabilities in the light of what at first can seem like hopeless neurological devastation (Aldridge 1991a; Jones 1990; Magee 1995a; Magee 1995b; Sacks 1986).

For some patients with brain damage following head trauma, the problem may be temporary resulting in the loss of speech (aphasia). Music therapy can play a valuable role in the aphasia rehabilitation (Lucia 1987). Melodic Intonation Therapy (Naeser and Helm-Estabrooks 1985; O’Boyle and Sanford 1988) has been developed to fulfill such a rehabilitative role and involves embedding short propositional phrases into simple, often repeated, melody patterns accompanied by finger tapping. The inflection patterns, of pitch changes and rhythms of speech, are selected to parallel the natural speech prosody of the sentence. The singing of previously familiar songs is also encouraged as it encourages articulation, fluency and the shaping procedures of language which are akin to musical phrasing. In addition the stimulation of singing within a context of communication motivates the patient to communicate and, it is hypothesized, promotes the activation of intentional verbal behavior. In infants the ability to reciprocate or compensate a partner’s communicative response is an important element of communicative competence (Murray and Trevarthen 1986; Street and Cappella 1989) and vital in speech acquisition (Glenn and Cunningham 1984). Music therapy strategies in adults may be used in a similar way with the expectation that they will stimulate those brain functions that support, precede and extend functional speech recovery. Functions, which are essentially
musical and rely upon brain plasticity. Combined with the ability to enhance word retrieval, music can also be used to improve breath capacity, encourage respiration-phonation patterns, correct articulation errors caused by inappropriate rhythm or speed and prepare the patient for articulatory movements. In this sense music offers a sense of time which is not chronological, which is fugitive to measurement and vital for the coordination of human communication (Aldridge 1996a).

Evidence of the global strategy of music processing in the brain is found in the clinical literature. In two cases of aphasia (Morgan and Tilluckdharry 1982) singing was seen as a welcome release from the helplessness of being a patient. The author hypothesized that singing was a means to communicate thoughts externally. Although the 'newer aspect' of speech was lost, the older function of music was retained possibly because music is a function distributed over both hemispheres. Berman (Berman 1981) suggests that recovery from aphasia is not a matter of new learning by the non-dominant hemisphere but a taking over of responsibility for language by that hemisphere. The non-dominant hemisphere may be a reserve of functions in case of regional failure indicating an overall brain plasticity, and language functions may shift with multilinguals as compared with monolinguals, or as a result of learning and cultural exposure where music and language share common properties (Tsunoda 1983).

That singing is an activity correlated with certain creative productive aspects of language is shown in the case of a 2-year-old boy of above-average intelligence who experienced seizures, manifested by tic-like turning movements of the head, which were induced consistently by his own singing, but not by listening to or imagining music. His seizures were also induced by his recitation and by his use of silly or witty language such as punning. Seizure activity on an EEG was present in both temporocentral regions, especially on the right side, and was correlated with clinical attacks (Herskowitz, Rosman, and Geschwind 1984).

Aphasia is also found in elderly stroke patients and music therapy, as reported in case studies, has been used effectively in combination with speech therapy.

Gustorff (Aldridge, Gustorff, and Hannich 1990; Gustorff and Hannich 2000) has successfully applied creative music therapy to coma patients who were otherwise unresponsive. Matching her singing with the breathing patterns of the patient she has stimulated changes in consciousness which are both measurable on a coma rating scale and apparent to the eye of the clinician.

Mental handicapped adults

Music appears to be an effective way of engaging profoundly mentally handicapped adults in activity (Wigram 1988). The functional properties of music have implications for the treatment of the mentally handicapped in that; (i) exposure to sound arouses sensory processes, (ii) a musical event is an organized temporal auditory structure with a beginning and an end, (iii) music facilitates memory recall and expectation (“the signature tune effect”); and, (iv) a sequence of
musical themes can enhance memory recall and the organization of a sequence of cognitive activities (Knill 1983).

For a group of profoundly mentally handicapped adults, music therapy was used to encourage those adults to attempt movements and actions, and achieve non-musical aims within the music therapy sessions (Oldfield and Adams 1990). Music therapy was compared with play activity using two groups of subjects. Each group received either music therapy or play activity for six months, at which time the groups were reversed to receive the comparison treatment. As the handicaps were so profound and varied between individuals then a separate behavioral index was formulated for each subject. It was hypothesized that each objective would be achieved to a greater extent in the music therapy group than in play activity. While the study was restricted in terms of numbers, and the behavioral indexes were varied, there was a significant difference in the performance in music therapy than in play therapy. This improved performance was not attributable to greater attention in the music therapy group. The type of input was noticeably different in the two groups; in the music therapy group improvisations were based on the subjects own musical productions. However, for one subject there was greater improvement in the play activity which came before the music therapy treatment.

Children

Much of modern music therapy was developed in working with children and the diversity and richness of this work is reflected in the literature. Stern (Stern 1989) emphasizes the importance of the creative arts in general to child development as they involve the child’s natural curiosity. However, she also proposes that in terms of child development then therapies must involve the family of the child particularly in the case of child disability. For children with multiple disabilities there is need for stimulation and this can be achieved using music which also provides a sense of fun and enjoyment. Stern’s approach suggests that songs stimulate a bond between therapist and patient, and that for one particular disabled patient “The music entered Susan’s frame of reference” (p649). An alternative explanation could be that music was Susan’s frame of reference by which she co-ordinated her own activities and those activities with another person. It may well be that families of handicapped children need to learn the rudiments of music therapy, as organized rhythmic communication, such that they can provide a structure for their mutual communications (Aldridge 1989). In this sense it make sense for therapists to work with both parents and children.

Songs, both composed and improvised provide the vehicle for working with hospitalized children (Aasgaard 1999; Dunn 1999).

Songs were also used in the preoperative preparation of children in an attempt to relieve fear and anxiety by transmitting surgery-related information. To ascertain the efficacy of using information alone, or information with songs, three groups of children were prepared on the day before surgery; one group with information alone, one group with information followed by specially
prepared songs which were based on that information; and a third group which also had information followed by songs with an additional session of songs immediately in the preoperative phase on the day of the operation. The group receiving music therapy on the morning prior to the induction of pre-operative medication exhibited significantly less anxiety based on a number of observed variables. Lessons to be learned from this research may be that although information is made available it does not mean to say that the child will be able to use this information when it is needed, no amount of information will make a procedure less painful, and a cognitive understanding of pain made during a therapy session is not necessarily translated into physical or emotional relief during the context of surgical preparation. Music therapy in its immediacy may have been a critical factor in reducing anxiety, as anecdotal reports suggest, but in this study no group received music therapy alone.

In a general study of music therapy as applied to newborns and infants in hospital (Marley 1984), music appeared beneficial as a calming effect inducing sleep and relaxation. The methods ranged from simple tapping on the back to simulate a heartbeat, through rocking of children in time to played music, to receptive music therapy. It is difficult to understand the nature of this work as music therapy. The researcher reports that in 13 of the rooms the television was off and in fourteen rooms the television was on. When the television was on in most cases the sound was either too low or too loud. It must be added that the children were between the ages of 5 weeks and 36 months old. With continuous sound stimulation then little wonder the children responded to the television being switched off and guitar music being played to them.

Fagen (Fagen 1982), working with terminally ill pediatric patients, also emphasizes the psychosocial setting of the family and the hospital as important. Music therapy in this setting was used to improve the quality of life of the patients in an attempt to broaden and deepen their range of living. However neither a quality of life scale was used, nor were the criteria for assessing the quality of life in dying children made clear. This is not surprising as no quality of life scales for children with terminal illness exist at present. In her music therapy practice Fagen was eclectic borrowing from various music therapy schools but concentrating on songs to confront the issues of hospitalization and dying. These songs often had improvised lyrics according to the needs of the situation, or songs that had given meanings and were appropriate to the patient. No attempt was made to force patients to confront their own dying.

Aasgard has pursued the theme of music therapy in pediatric oncology further. He uses songs to facilitate a return to health, where health is seen as a performed activity within ecology of care (Aasgaard 1999). These songs are no however privatized productions, but shared pieces of music that are sung by siblings, family members, and hospital staff.

Creative expression, as reported in the work with children, is generally accepted as a means of coping whereby pain and anxiety are channeled into activities (Lavigne,
Schulein, and Hahn 1986). In an attempt to encourage children to cope with the trauma of hospitalization by verbalizing their experiences, Froehlich (Froehlich 1984) compared the use of play therapy and music therapy as facilitators of verbalization. When specifically structured questions about hospitalization were asked of the children after sessions of music therapy or play therapy, music therapy elicited more ‘answers’ than ‘no answers’, and a more involved type of verbalization involving elaborated answers, than play therapy.

**Autism**

Music therapy allows children without language to communicate and possibly to orient themselves within time and space. It has developed a significant place in the treatment of mental handicap in children. Children exhibiting autistic behavior appeared to prefer a musical stimulus rather than a visual stimulus when compared with normal children (Thaut 1987). Although the significance of this finding was not statistically valid; the study does report that autistic children showed more motor reactions during periods of music than normal children, and that autistic children appeared to listen to music longer than their normal peers who preferred visual displays.

In a later study comparing autistic children and their normal peers (Thaut 1988), autistic children produced spontaneous tone sequences almost as well as normal children and significantly better than a control group of mentally retarded children. Each child sat at a xylophone with two beaters, after having had a short demonstration from the researcher, who then asked them to play spontaneously for as long as they liked until they came to a natural ending. The musical parameters, of the first sixteen tones of these improvisations, which were assessed and used as the basis for group comparisons were; rhythm (representing the imposition and adherence to temporal order); restriction (representing the use of all available tonal elements); complexity (representing the generation of recurring melodic patterns; rule adherence (representing the application of melodic patterns to the total sound sequence); and, originality (representing the production of melodic patterns that occurred only once but fulfilled criteria of melodic and rhythmic shape). Autistic children perceived and explored the xylophone as normal children did in terms of originality and restriction, but tended to play with short recurring motives rather like the mentally handicapped children. Thaut (1988) concludes, “The low performances on complexity and rule adherence of such children suggest an inability to organize and retain complex temporal sequences” (p567). This relationship between cognition and motor behavior as it is co-ordinated in rhythmical performance, as we have read above in terms of heart rate, breathing, muscle performance and speech rehabilitation, would appear to be worthy of investigation in a wide variety of patients with communication difficulties regardless of the source of those difficulties.

Music therapy has been used extensively in the treatment of developmental delay. In a crossover study (Aldridge, Gustorff, and
Neugebauer 1995), the children in the initially treated group changed more than the children on the waiting list. When those waiting-list control group children were then treated with music therapy, and the formerly treated children rested, then the newly treated children caught up in their development. Such changes were demonstrated at a level of clinical significance. There was a continuing improvement in hearing and speech, hand-eye coordination and personal-social interaction. While active listening and performing were seen to be central to the developmental process, it was the importance of hand-eye coordination skills emphasized in the active musical playing which were instrumental in encouraging cognitive change.

Conclusion
There is a broad literature covering the application of music therapy as reported in the medical press and a growing resource of valid clinical research material from which substantive conclusions can be drawn. The obscure observations in the realm of psychotherapy highlight a critical feature of music therapy research; well intentioned, and often rigorous work, is spoiled by a lack of research methodology. This is not to say that all music therapy clinical research should conform to a common methodology (Aldridge 1996; Aldridge 1999; Aldridge 2000), or that it be medical research, rather that standard research tools and methods of clinical assessment be developed which can be replicated, which are appropriate to music therapy, and develop a link with other forms of clinical practice. In this way we develop working tools which allow us to inform others and ourselves. There is a lively debate in music therapy circles about appropriate methods and a variety of books have addressed themselves to presenting research material and methods (Wheeler 1995).

The research that has been produced is notably lacking in follow up data, without which it is difficult to make valid statements about clinical value. The assessment instruments are generally lacking by which internal or external validity can be conferred. For example, as ‘depression’ appears to feature in many chronic diseases then a clinical rating of depression, using a validated scale, would be appropriate to include in a research design. If this assessment of depression could be combined with an overall assessment of life quality then a significant step forward would be made in establishing a minimal data set for assessing clinical change.

Much of the research work has been developed within the field of nursing where the use of music is accepted as a useful therapeutic adjunct. Not surprisingly, the work from this field has concentrated on medical scientific perspectives. There is almost a complete absence of cross-cultural studies, or the use of anthropological methods that would bring other insights into music therapy. That music has been used therapeutically in other cultures cannot be denied, and other perspectives regarding the application of music therapeutically would highlight the limitations of modern Western scientific approaches when used as the sole means of research.


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Performance and Product:  
Clinical Implications for the Music Therapist

Introduction

Can a music therapist be fully attending to the needs and issues of their clients when performing with a client or group of clients? What happens when the therapy consists of or includes working towards a product such as a recording of music from sessions? How can we discern what clients can benefit from these experiences and when it may be contra-indicated? As the music therapy profession has developed, the idea of therapists performing and creating products with clients has become a controversial subject. There are many issues to be aware of when integrating performance and creating products in our clinical work.

Background [1]

When the field of music therapy was in its infancy, music therapists were often hired on lines that were previously relegated to recreation therapists or music teachers [2]. Music teachers in special education often did performances with their students, and music therapists struggled to establish their own professional identity. Some therapists who were trained to use music in a recreational fashion were unaware that there were other considerations aside from the product. The music therapy literature contained research which described how clients "performed." Music was used
instructionally, as a reinforcer, and quantitative research was done to measure "music performance behaviors [3]." Some supervisors of music therapists considered performances and products to be natural outcomes when the music therapist worked with their clients. Often therapists were given large amount of clients to work with simultaneously, which made it extremely difficult to do activities besides performance. Structured activities, including sing-alongs and rhythm band type of performances, were often chosen as the only way for the therapist to work. There were times when administrators dictated to therapists that they were expected to perform publicly with their clients in order to increase visibility

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[1] Though I have done some research in discussing the historical development of performance and product in music therapy, I admit that some of the ideas I am presenting are conjecture, based on my analysis of the situation rather than first hand accounts.

[2] Ruppenthal, one of the founders of the NAMT and one of the first registered music therapists to work in psychiatry, described a battle (that he eventually won) over maintaining his autonomy rather than being part of a centralized department with occupational and recreational therapists. He describes some of the events in his program as rhythm bands, church choirs, and vocal and instrumental ensembles. Despite the fact that he considered himself a Freudian, he spent much of his early years in psychiatry creating performance type activities with patients.

[3] For example, in the Journal of Music Therapy, Vol.XIV, Dorow "dealt with the reinforcement value of musical performance using free operant selection." Her study set out to "determine the effects of high approval instruction versus discovery method on performance achievement." Subjects were administered a "recorder performance posttest". In her summary she concludes by stating "it is clear that beginning instrumentalists, students in elementary school general music programs, or clients in music therapy instrumental programs need structured instructional programs with the music itself and music performance being paired with reinforcement in order for them to find reinforcement value in performing." It is debatable whether this study would be considered relevant to contemporary practicing clinicians.
and awareness of music therapy in their facilities. Therapists were forced to participate in these kinds of activities or risk losing their jobs. The therapist created vocal choirs, bell choirs, and other recreational types of musical performances. Some utilized performance willingly without conflict; others went along with the idea though they wanted to do something else [4].

Though this kind of work may have been beneficial in some respects, through the lens of a contemporary music psychotherapist it would seem to be potentially hazardous to the therapeutic relationship. By setting the goal of a good performance as a high priority, patient's issues may have been ignored by the therapist. The therapist was forced to consider his own agenda and might not have been as focused or aware of the client's process. The clients may have experienced a sense of being abandoned and exploited, not valued for who they were but for what they did for the therapist. The therapist may have internalized the message from his supervisor to focus on the musical product rather than on the client's process—that success was measured on how the performance was perceived rather than on its effect on the clients overall progress.

In the early days of the profession, when many therapists did perform and produce products with their clients willingly, they were unaware of these potential hazards, and unaware of their own personal motivations that might have impeded on the therapy process in a destructive way [5]. Under the guise of helping the client or promoting the field, therapists may have been acting on their own hidden agendas such as self-promotion, the need to feel self-important, and the need for recognition and acknowledgement. Some saw themselves as the only person trying to help the clients do something positive rather than reduce them to a diagnosis, and placed themselves unconsciously in the position of savior. They may have felt that music was the way to save the client, since music might have functioned for themselves in this way. They may have wanted their own music to be heard, and utilized the patients participation in order to achieve this. Perhaps the therapist was also a musical performer and assumed that since he enjoyed doing it, the patients would also. Perhaps the therapist chose to be a therapist in order to avoid the performance anxiety that comes with being a musician. Perhaps the performance was a way for the therapist to work on his own issues. Perhaps the therapist had always wanted to have his own band. These unconscious dynamics were potentially damaging for the client. The basic problem was this: if the therapist was acting on his own unmet desire to be a performer or professional musician, who was watching out for the clients? Unconscious motivations were impeding on the therapy process and preventing the therapist from working on a deeper level with his clients, whether the therapist acknowledged the importance of unconscious motivations or not.

Of course, therapeutically beneficial performances and products did occur during the early stages of the profession. Successful events and products helped to create hope
Even today, music therapists, particularly those trained at undergraduate facilities, are running these types of activity oriented recreation groups. Manufacturers of musical instruments continue to create instruments that make it possible for disabled people to perform.

I am deliberately avoiding the use of the term countertransference, as this term implies an awareness of the therapeutic relationship that simply wasn't present for most, if any, music therapists at this point in the field's development.
and raise the self-esteem for clients who participated. Clients gained a sense of mastery and confidence in presenting themselves publicly. When performing as a group, support and camaraderie developed among clients. A feeling of community helped to create a sense of belonging and self-worth for clients. Pioneering music therapists such as Nordoff and Robbins were able to successfully integrate performance into their clinical practice. In their book, *Therapy in Music for Handicapped Children*, they describe the benefits of working in rehearsal for a performance of the piece "hist-whist." The piece was written specifically for the clients to perform. Eight sessions were required to "perfect" the piece, and the hard work in achieving this was "where the therapy lay." They also worked on performing musical plays with children, and the resulting performances changed the way the children were perceived by their housemothers, therapists and teachers. Nordoff and Robbins felt that "the performance was the summation of a therapeutic process that had its origin and development in the rehearsals." The children became "a team of performers, sharing new experiences that their own efforts made possible." Nordoff and Robbins carefully studied the effects of these events on the children, recording each session and reflecting on the benefits of this kind of activity. Dr. Herbert Geuter supervised them, and often made suggestions about the activities, which were based on anthroposophic teachings.

Therapists utilized performance in a variety of settings with a wide range of client populations. Schmidt-Peters (1987) surveyed the field for her book, *Music Therapy: An Introduction*. She described the work with a variety of populations including visually impaired clients. She stated that "group music activities, such as dances, singing groups, and instrumental ensembles, can provide places for visually impaired clients to learn skills to interact and socialize with each other and with sighted individuals." She goes on to say that some may be able to support themselves by performing. She added that visually impaired clients need not become performers in order to reap the benefits from music. She also described how ensembles, such as community choirs, can be used therapeutically to cultivate self-confidence and leadership abilities, and facilitate adjustment to school and community for socially maladjusted adolescents.

Shulberg (1981) listed choral singing as an activity that can promote socialization, and stated that the group could prepare a presentation to sing to others. She has an entire chapter in her book on music therapy entitled, "Musical Productions." Shulberg believed that "when a production of any sort is created and then brought to life by it's creators, the performance transmits their capacities for care, perception, and cooperation to the audience, who also experience the commitment and sense of fulfillment of these participants." She was careful to state that the "production itself is the means, not the end."

In other types of adult facilities, performance also had successful outcomes. Michel (1976) describes how men who were members of a popular music combo in prison continued to play together as a commercial group when they were released from prison.

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Advanced Training

As music therapy training programs became interested in more depth-oriented work, music therapists integrated process-oriented philosophies into their clinical practice. As therapists trained in more advanced ways, the significance of performance and product became more fully understood. Rather than having extrinsic music activities imposed on clients, therapists came to value the music created intrinsically by clients. As the field developed, the importance of reflective supervision to examine the dynamics of the relationship between therapist and client helped bring awareness to the therapist the many dynamics that might come into play. The masters program in music therapy at New York University developed by Barbara Hesser helped to pioneer music psychotherapy, and product-oriented activities were understood as part of a supportive approach to music therapy, rather than the deeper levels of reeducative or reconstructive music therapy.

Therapists began to question the benefits of performance. The rationale behind performance was looked at closely, and often was seen as impeding the clients need for self-expression which would not be judged aesthetically by an audience, but was important in and of itself for the clients self-discovery and emotional contact to the therapist. It was seen as valuable for the client, rather than looking for external validation by performing, to discover meaning and worth based on looking within. Self-reflection, rather than public acknowledgement, was encouraged.

Personal Experience

In 1979, as I began my experiences at Bellevue hospital, performances were done with both psychiatric adolescents and adults. The process was often difficult, and there were times when the client was unable to follow through on the performance. The therapist, aware of the dynamics inherent in music psychotherapy as an approach, was careful to guide the process and see it as a step in the clients overall treatment. Clients could easily sabotage their own performance due to a lack of self-esteem and the inability to face up to the challenge of performing. Performance was seen as a part of, not the end product, of the music therapy process. For some clients, the challenge of working towards a public performance was similar to Campbell's description of "The Hero's journey". By focusing and disciplining himself, the client was able to face his fears and play music publicly, and the experience left him feeling better about himself.

During the early 1980's, performance was also integrated into the work done by creative arts therapists at Metropolitan hospital with psychiatric adolescents. Music was performed at graduation ceremonies and during groups where parents participated in the music making. These events were considered meaningful and important in creating an atmosphere of trust and support among clients and staff. Performance was a way for these clients to make a statement, begin to establish their own identity, and express themselves in a way talking could not.

Underlying Dynamics of Performance
For some clients, however, receiving the external validation that comes from sharing publicly did not have a beneficial effect on the client as a whole. Even when others acknowledged the performance or product as successful, the client was not satisfied. For those clients, the desire to perform and receive public acknowledgement was an attempt to fill an emotional need for nourishment and connection that was never met interpersonally. No matter how much public sharing and acknowledgement, the client continued to feel unsatisfied, driven to perform again. They were unable to share the spotlight with their peers. Their relationship to others in every day interactions continued to be difficult.

Psychoanalytic theory has described the person who consistently seeks external notice by performing, who achieves public acclaim yet continually feels an underlying sense of emptiness and shame, to be suffering from narcissistic personality disorder. When early in their lives their basic needs are unmet by a distant parent who needs their child to be special in order to feel self-worth themselves, the child experiences a feeling of abandonment and rejection. The child grows to be an adult desperately seeking recognition and "specialness" as a way to defend against feelings of inadequacy and powerlessness. Though he may have an exaggerated view of his talents and accomplishments (grandiosity), this is a fragile state and considered a defense. What is driving this exaggerated self importance is that deep down he feels hopelessly unlovable and defective, so he seeks to create an ideal self through the pursuit of celebrity and external success. He constantly depends on others for approval and recognition. It is very difficult to establish trusting, intimate relationships for a person struggling with these issues.

Lasch, a psychoanalyst and social critic, wrote in his seminal book, "The Culture of Narcissism", that this kind of personality structure is indicative of our contemporary society. It is not an isolated phenomenon to be found only in pathological states, but is created by the values and systems of our culture and is therefore present in all of us to a greater or lesser degree. Contemporary American culture places a high value on image (over substance), celebrity (over real accomplishment), self (over community), immediate gratification (over consideration of links to the past and the meaning for the future) and commercial success (over intrinsically meaningful work). He feels that these are symptoms of a lack of true emotional connection and belonging among people. In his view, we are all susceptible to these feelings of emptiness or inadequacy, and to combat them by yearning for fame or external recognition. It may be helpful for the music therapist to look at these phenomena in a broad sense, that there is a continuum where potentially every client who seeks to perform may have these issues lurking somewhere. It is also important for the therapist to see if his own motivations to perform with clients is stemming from this very same issue- his own desire to be recognized publicly as a defense against feelings of inadequacy or emptiness. It may be a countertransference reaction- that he is experiencing something lacking emotionally in the relationship with his client and is dealing with it by deciding to perform- or is acting on the clients unspoken desire to perform.
Despite the fact that the external validation that comes from public acknowledgement does not vanquish these feelings of emptiness and inadequacy, performing may be an effective component of music therapy treatment with this kind of client. Kohut, the renowned psychoanalyst who identified this dynamic in his patients, felt that "useful, creative work, which confronts the individual with unsolved intellectual and aesthetic problems" was the way to try to help these patients. He felt it was important to try to mobilize the "narcissistic impulse" on behalf of activities outside the self. The creative act of music making can be seen as a step in this direction. The music therapist could utilize performance as a way to engage the client who felt the need to perform. For clients struggling with this core issue, processing their feelings after the performance or completion of the product could help them to feel valued as a person, worthy not solely for their external achievements but for who they were in totality. In other words, in psychoanalytic terms, there is a healthy narcissistic impulse in all of us that can be addressed constructively, rather than pathologized.

**Strategies**

A key element in successfully integrating performance and product into the music therapy relationship can be the processing of the therapy partnership. The relationship between therapist and client changes when they perform or create a product together. Roles can become confusing, boundaries unclear. Some clients, in order to avoid working on difficult issues or feelings, may try to defend themselves by abdicating their role as client and try to ignore the therapist's role. This can happen when both therapist and client are performing together and experience each other in a new context. It can be important for the therapist to emphasize that he is still observing and guiding the therapeutic process even as he collaborates as a performer with the client. The therapist needs to guard against dual roles that may compromise his focus on the client's development.

**Clinical Vignettes**

Brian Wilson, composer and creative force behind the beach boys, described his therapy relationship with the psychologist Dr. Eugene Landy in his book "Wouldn't it be Nice." Wilson was struggling with schizophrenia and chronic drug use when Landy began working with him. During the course of therapy, Landy began to write songs with Wilson. Wilson writes, "with Dr Landy, I worked on "Child, Adult, Parent," a suite that mirrored, in music, the transitions my own life had undergone. The collaboration was among the most fascinating I'd ever been engaged in, involving nearly constant analysis and discussion." Wilson credits Landy with getting his life back together and helping him rediscover his abilities as a composer. Landy had many roles with Wilson. He was his executive producer, business manager, and co-songwriter. Wilson describes Landy as saving his life-"he returned my career to me." Landy took charge of Wilson's career and co-produced an album with him. This created controversy. Landy's detractors claimed that Wilson was brainwashed. Despite Wilson's obvious improvements, the Board of Medical Quality Assurance of California charged Landy with ethical and licensing code violations. They stated that during treatment a therapist should not enter into any nonprofessional relationship with a patient. The charges implied...
that Landy took advantage of Wilson. Wilson ponders the situation this way:

My situation had presented extraordinary circumstances, and Dr Landy by reputation was an extraordinary therapist—the reason he'd been contracted originally. At a certain juncture, he was faced with a dilemma created by the state’s canon: Is it ethical to take a patient to a certain point and then leave him there because the ethics say not to go any further? Should he depart from his traditional therapeutic process and enter into another role in which he could help me or should he not help because of an ethical process? Should he stop at a certain point because ethics imposed restrictions, or should he throw ethics to the wind and continue to improve my life? Dr Landy and I ended our formal doctor-patient relationship. Dr. Landy became my friend, partner, and manager. If he and I were going to collaborate, we had to have equality.

It is obvious that Wilson valued the partnership between he and Landy. Wilson seems to be saying it was not possible to feel like an equal with Landy within the therapeutic relationship. It could be that the therapy relationship became too confusing for Wilson to continue as it was. Landy felt he had to get involved with all aspects of Wilson's life in order to help him. It is unclear whether Landy was discussing the implications of his many roles with Wilson. In the book Wilson describes Landy as an ally, though at times Landy seems more concerned with the product he was producing with Wilson then the effect on Wilson as a whole. It might have been intoxicating for Landy to be working with an artist of Wilson’s stature. It is unlikely that this kind of creative music-making situation had ever arose before for Landy, a psychotherapist. He was not a professional musician, and may have had undifferentiated feelings associated with creating music with Brian Wilson. He was not prepared to enter into the creative process and be an observer of the process, as music therapists are. As music therapists, we try to be prepared for these issues to arise. Music is created to be heard by others, and clients may naturally want to share their music with others. For music therapists, performance and product can fall within the purview of the music therapy relationship. We attempt to be able to play while observing the process-to attend to others even as we create with them in front of an audience. At times, we need to take actions that may not feel natural to us, but benefit the client in the long run.

I have been in therapeutic relationships where I established a clear boundary by encouraging the client to perform with another musician, rather than with myself as his therapist. This was not easy to do, and I certainly felt an attachment to the songs and the client. I made the decision based on what I felt the client needed. This actually helped the client to take initiative, gain a sense of independence, and attain a strong sense of accomplishment which helped him continue pursuing music as a career, without relying on me to participate with him. I did attend the concert, and we processed what it was like in the subsequent therapy session.
Austin (personal communication 1999) has performed with clients and also chosen not to perform. She feels that there are certain clients who are too fragile and unable to tolerate experiencing their therapist as not attending solely to their needs. Austin described one client who thanked her for saying no after the client asked to perform together. This was a significant moment in the therapy relationship, as Austin felt the client could trust her and experienced a sense of safety as they continued to work together.

There have been times when I have chosen to perform with a client. In order to maintain the therapeutic alliance it may be vital to share thoughts and feelings about the performance or product after it is shared. During these kinds of public events, the therapist may reveal parts of themselves that the client had never been exposed to before. This can have a powerful effect on the relationship. When the client sees their therapist not functioning solely as the container and caretaker of the therapy process, but also as a performer focusing on their own performance or producer working on a product, strong feelings may arise. Feelings of being abandoned, and anger toward the therapist may manifest. What if the therapist makes an obvious mistake as a performer—how will the client experience this? What if the client makes a mistake? Will the client feel that they let down the therapist as well as feeling disappointed in their own performance? What if the therapist gains more applause? Are there feelings of competition between therapist and client that get played out? Will the therapist develop personal feelings over the product they created with a client? Will there be issues over who controls the product created in a therapy session? These potential issues are "grist for the mill" if the therapist is ready to work with them.

How Therapeutic Process effects Performance

Many of the issues that arise when performing or creating a product may feel familiar to the client, and in fact could be a reliving of experiences he had with his parents. The client may have had parents who demanded improvement whenever the client performed, or only paid attention and acknowledged the client when they performed. Having a successful performance while being attended to by the therapist, the client may experience a powerful sense of satisfaction. By experiencing performance in a new way with the therapist, the client may be able to become aware of issues and deal with feelings that were previously too difficult. The therapist provides a corrective emotional experience by being emotionally present, able to be present with the client's feelings, whether they be joy or rage, happiness or sadness. Even if the event was considered a success, the therapist needs to be ready for any reaction the client may have. This may be more difficult than a normal therapy situation for the therapist as he has also performed and may have more personal investment in the client sharing in a positive experience with him.

The client may transfer strong feelings that have been unresolved since childhood onto the therapist. By engaging in an exploration of these issues, the therapist helps the client become more aware of and deal more realistically with his emotional reactions. These issues may manifest themselves in the music improvised by the therapist and client in subsequent sessions.
The therapist will need to be on the lookout for dynamics that arise when performing with a client or producing a product with them. It may be difficult for the client to discuss them; but exploring these issues has the potential to enhance the relationship and the therapy process for the client. The client may feel a great sense of relief that he does not have to hide the feelings that are brought up during the performance process. By sharing private feelings that came up in a public forum, the client through time may be able to integrate the vulnerable and omnipotent parts of himself and not maintain either a grandiose or inferior position. The client may reflect on the process and make new discoveries, gain new insights. They may establish a more intimate, satisfying relationship with the therapist, able to trust their feelings and build a meaningful connection. They may begin to see themselves as worthy of care for who they are, rather than for what they do. Instead of feeling insecure and inferior, they may be able to experience themselves as an equal member of the therapy team. They may begin to feel less driven to perform due to a need to maintain their esteem, and make the choice to perform when they have something they want to share with others. They begin to see the performance as a way of learning about themselves rather than a way to feel superior. They look forward to performing as a way to feel invested in the future, rather than a way to stem feelings of emptiness. They may accept their mistakes more easily rather than expect perfection each time they perform. Each performance can help to indicate what is going on in the client's inner life. The focus is on the client's inner development and process through time.

**Contemporary Work**

Presently, music therapists working with a variety of populations are choosing to perform publicly with their clients, and focus on products to be heard outside of sessions. Peter Jampel and Sten Roer, among others, have formed rock bands with their psychiatric patients. The process of traveling and working together has helped their clients to feel more confident, and more integrated into the community. Jampel has made a point to call this kind of work rehabilitation rather than therapy, yet has created a therapeutic environment based on the idea of approaching performance as a vehicle of potential development for his clients [6]. Emma O'Brien has recorded songs of clients with terminal illnesses. These clients have described the recording project as giving their life purpose, and feeling less isolated [7]. David Ramsey has made multi track recording the focus of his work with neurologically impaired clients, and has arranged for performances of the

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[6] Jampel sites Newman as an influence in building a safe space for performance. Newman is the founder of social therapy, a "cultural-performatory method for curing emotional pain and psychopathology." Newman believes that performance is the natural way to change and grow, and, in fact, children do this in their play. Performing, in his view, promotes development, and being social has a performance aspect to it. Performing gives the person an opportunity to try on new behaviors and attitudes.

[7] O'Brien, like Landy, was under pressure from those within the profession who felt it was unethical for a therapist to be economically supporting her program with the profits of recordings made by patients and herself. She has stated that the idea of giving the proceeds to the music therapy program she runs came from the patients themselves.
music within the hospital setting. This has helped to change how these clients view themselves—from identifying themselves as a damaged patient to someone who can accomplish and experience a sense of completion and wholeness. Rather than feeling helpless they are motivated to work and rehabilitate. They have been able to find ways to express themselves, as Ramsey has found the technical means to allow them to create music despite their disabilities [8].

Sharing the results and accomplishments publicly of the music created privately in a music therapy session can be a way of cultivating a sense of achievement within the client. Public sharing can be a way of validating changes the client has made internally. Maria Logis, a client who has worked with me in music therapy and has shared her process publicly, has stated that sharing the music she has created in music therapy sessions has helped her to "reclaim" her voice. She began public sharing by playing audiotapes of her music therapy sessions with close friends and family. The improvised music contained thoughts and feelings not just about her illness [9] but about life long issues. In this way she felt she successfully communicated her feelings in a way she could not verbally. She decided to learn the music created in sessions and sing the music publicly for friends and family. The act of sharing gave her the experience of overcoming her feelings of isolation, and she describes that she now has more options besides hiding in a private world of self-criticism. Explaining her process in music therapy to music therapists, Logis feels, has given her life a sense of purpose. She continues to seek out public projects that allow her to share her music therapy journey.

**Conclusion**

Performing with clients is a legitimate activity that can bring many potential benefits to the client. Recording music created in therapy sessions can allow clients to share personal feelings and expressions to others in a meaningful way. These activities can create a sense of accomplishment and self worth within the client. It is important for the therapist to determine what the important dynamics and issues are for the client in order to discern what performing or recording will mean for the client. The therapist can help the client concentrate on the product while being aware of the overall process of the therapy. It is important for the therapist to realize that the client may have many reactions to a successful performance—that successful performance or product does not equal successful therapy.

The performing process can bring up new issues and areas of development, which feed back into the therapy process. Experiencing a sense of being valued and being attended to after the performance by the therapist, clients can feel an internal sense of validation and nurturing that can be more powerful than the public response. With supervision, which examines underlying motivations and dynamics, reflecting on the process and examining how the performance and product effect the client, therapists can successfully integrate these activities into their music therapy practice.
Ramsey, who has experience working within the psychoanalytic framework, feels no conflict to be working on performance and products with his clients. He explains that the clients he is currently working with are "not suffering from bad mothering," and thus he concentrates on the task of creating music, ready and available to deal with underlying emotional issues if they arise.

Logis has non-Hodgkin’s Lymphoma that is currently in regression, which means the tumors have shrunk but are still present.
References


Formen der Begegnung - Wege zum Dialog

[Viel Dank für die Einladung und für die Aufforderung, einen Beitrag über meine Arbeit als Sozialarbeiterin auf der psychiatrisch-psychotherapeutischen Abteilung des Gemeinschaftskrankenhauses Herdecke ausführen zu dürfen.

Der besseren Verständlichkeit willen, werde ich oft nur die männliche Form gebrauchen, die weibliche Form ist selbstverständlich immer mit gemeint. Die hier aufgeführten Namen sind frei erfunden.

Zuerst dachte ich an einen Scherz, als Peter Hoffmann mich um ein Referat auf einer Arbeitstagung zur Musiktherapie ansprach - schließlich verläuft nahezu nichts unmusikalischer als eine Sozialberatung ... - aber Begegnung und Dialog finden natürlich auf unterschiedlichste und manchmal recht spannende Art und Weise statt.]


Einen Arbeitsauftrag kann ich vom Arzt, vom Patienten selbst, von den Pflegenden


Aber auch eine Erweiterung und Entwicklung individueller Handlungskompetenz durch Beratung, Bildung, Unterstützung und Anleitung sehe ich als meine Aufgabe an.


Auf der Grundlage der ersten Einschätzung besprechen wir die Hilfeplanung (Planing). Als Zwischenschritt muss festgestellt werden, welche Lösungsversuche in der Vergangenheit schon fehlgeschlagen sind oder gar fatale Auswirkungen hatten. Dann suchen wir nach möglichen Alternativen.

Die Durchführung (Intervention) der Massnahmen beinhaltet die Erschließung der Ressourcensysteme, so dass die geplanten Ziele erreicht werden können.


Aufgrund der begrenzten Verweildauer der Patienten im Krankenhaus ist es wichtig, schon zu
Beginn der Beratung, das Ende der Unterstützung zu thematisieren und zu planen (Disengagement). So kann sich der Patient als gleichberechtigter Partner im Beratungsgeschehen erleben.


Manchmal fühle ich mich von meinen Kollegen im Team auf ein bestimmtes Schema reduziert: "ah, der Patient braucht Geld ..." - zur Sozialarbeiterin schicken ... "Probleme mit Finanzen ..." - dafür ist doch die Sozialarbeiterin da ... Besonders Finanzprobleme und Sozialarbeit sind in der Vorstellung vieler Kollegen eng miteinander verknüpft ...!


Wenn es mir gelingt, gegenüber dem Patienten so zu handeln, dass sich für ihn die Anzahl möglicher Entscheidungen erhöht, habe ich schon viel erreicht.


Es kann aber auch sein, dass ein Patient selbst ungeduldig und frühzeitig auf Entlassung drängt und mir am Ende eines Gespräches zu meiner Überraschung mitteilt, dass er nun gesund ist und
am nächsten Tag die Station verlassen wird.

Wenn es die Entscheidung des Patienten ist, muß auch das Aufrechterhalten eines psychotischen Lebensweges akzeptiert und diesem Achtung und Respekt entgegengebracht werden. Das fällt mir zugegeben manchmal echt schwer!


Einige Wochen ist er bereit, Medikamente einzunehmen, dann lässt er sie weg und es dauert einige Monate, bis die Krise da ist und Herr Otto stationär aufgenommen wird.


Ich versuche in der Beratung eine offene Gesprächsatmosphäre zu schaffen, die den Patienten in seiner augenblicklichen Situation ernst nimmt und eine Bewertung, besonders die Zukunft betreffend: "... wenn Sie sich weiter so verhalten, werden Sie im Abseits landen, ...". zu unterlassen.

Es gibt noch andere Interessensgegensätze, die sich nicht auflösen lassen und wo ich den Wünschen und Vorstellungen des Hilfesuchenden, der Angehörigen und zum Beispiel der Pflegenden nicht unmittelbar entsprechen kann.

Frau Schneider, eine alte Dame, die zur Abklärung ihrer zunehmend auftretenden Verwirrheitszustände aufgenommen wurde, erzählt mir im Erstgespräch, sie sei zur Erholung in das Krankenhaus gekommen und dass sie auf jeden Fall wieder in den Haushalt der Schwiegertochter zurückkehren wird. Für einen Heimplatz interessiere sie sich überhaupt nicht und ausserdem könne sie ihre Familie nicht im Stich lassen, sie wird gebraucht ...

Die Pflegenden berichten über den umfangreichen Hilfebedarf von Frau Schneider und den Bemühungen, sie in den Stationsalltag zu integrieren, was aber an der ausgesprochenen Umtriebigkeit, dem Starrsinn und der Verwirrtheit von Frau Schneider zunehmend scheitert. Medizinisch-therapeutische Massnahmen und Medikamente bewirken keine spürbare Verbesserung der Situation.
Auftrag: Ist eine baldige Verlegung in ein Heim möglich?
Die Schwiegertochter und der Sohn sind mit der häuslichen Situation überfordert. Durch den Krankenhausaufenthalt fühlen sie sich entlastet. Eine Heimunterbringung können sie sich vorstellen, möchten aber die Entscheidung nicht verantwortlich tragen und daher auch nicht die rechtliche Betreuung von Frau Schneider übernehmen!

Aus medizinischer Sicht gibt es nach zwei Wochen keine Indikation mehr, Frau Schneider weiterhin stationär zu behandeln.

Die Tochter von Frau Schneider will eine Heimunterbringung vermeiden, da sie befürchtet, zu Zahlungen für die Heimunterbringung herangezogen zu werden. Sie will die Entlassung in den Haushalt ihrer Schwägerin, schließlich hätte sie den Vater auch bis zum Sterben in ihrer Familie gepflegt ...!

Die unterschiedlichen Sichtweisen werden von den Familienangehörigen in einem Gespräch mit mir offen und konfrontativ dargestellt.

Einigkeit herrscht nur in der Forderung, den Krankenhausaufenthalt um weitere Wochen zu verlängern!

Die Pflegenden und der Arzt drängen auf Verlegung in ein Heim, Frau Schneider will nach Hause!

Während meiner Bemühungen wird deutlich, dass die Entlassung noch einige Wochen dauern wird, da erst eine rechtliche Betreuung per Eilverfahren eingerichtet und ein freier Heimplatz wohnortnah gefunden werden muss. Die Zeit kann genutzt werden, um Frau Schneider und den Angehörigen die neue Lebensperspektive näher zu bringen.

Es kann aber auch passieren, dass sich Patient und Behandlungsteam scheinbar wohlig im therapeutischen Bemühen eingerichtet haben und es ein "außen" für sie nicht mehr gibt.

Frau Müller nimmt engagiert an den Therapien teil, hat gute Ideen, bemüht sich redlich und ist in jeder Hinsicht eine Bereicherung für den Stationsalltag. Der Arzt, die Pflegenden und die Therapeuten sind sehr zufrieden und es entsteht eine behagliche und harmonische Atmosphäre, wenn in der Patientenbesprechung Frau Müller an der Reihe ist.

Bis zu dem Tag, an dem ich von dem Gespräch mit Frau Müller berichte, in dem mir klar wurde, dass Frau Müller keine Krankenversicherung mehr hat, weil in den letzten Monaten vor Aufnahme im Krankenhaus keine Beitragszahlungen erfolgten, dass Frau Müller kein Einkommen hat, weil sie ihren Leistungsanspruch gegenüber dem Arbeitsamt nicht geltend gemacht hatte und dass eine Räumungsklage läuft, weil Frau Müller zum wiederholten Mal im Mietrückstand ist und auf Mahnungen nicht reagierte, überhaupt die Post der letzten Wochen ungeöffnet weggeworfen .... Vorbei ist die gute Stimmung in der Besprechung - "alle sind wieder geerdet ...!"

Es ist meine Aufgabe, den Alltag des Patienten "draussen" in die Behandlung "drinnen" mit einzubeziehen, was manchmal fast als Störung erlebt wird. Der Patient möchte sich nicht aufschrecken lassen und seine Sorgen "vergessen".

Das Aufarbeiten von Problemen wird auch in den Therapiestunden spürbar, der Patient wirkt auf
einmal wieder unkonzentriert und sorgenvoll, der Therapeut ist überrascht.

Dies zeigt einmal mehr, dass eine fruchtbare psychiatrische Arbeit nur in der Zusammenarbeit aller Berufsgruppen gedeihen kann. Daher ist es unverzichtbar, dass sich die Pflegenden, Ärzte, Therapeuten und Sozialarbeiter im ständigen Austausch befinden und ein ungehinderter Informationsfluss besteht.

Die umfassende Betrachtungsweise von Krankheit und Krankheitsgeschehen gewinnt durch sozialarbeiterisches Denken und Handeln eine Erweiterung der medizinisch-pflegerisch-therapeutischen Sicht um die soziale gesellschaftliche Komponente.

Elke Paulsen

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Entwicklung des Kommunikationsverhaltens, des improvisatorischen Spielausdrucks und der Psychopathologie im Verlauf einer Gruppen-Musiktherapie mit schizophrenen PatientInnen

Lodemann, E., Plum, F.J., Finkbeiner, T., Gastpar, M.

I. Einleitung / Fragestellung

Der vorliegende Bericht stellt erste Ergebnisse einer explorativen, praxisbegleitenden Studie zur psychotherapeutisch orientierten Gruppen-Musiktherapie dar. Untersucht wurde die Entwicklung von Ptn. mit der Diagnose 'Schizophrenie' im Verlauf einer 9-wöchigen Musiktherapie, und zwar unter drei Gesichtspunkten:

- Psychopathologische Verfassung
- Improvisatorischer Spielausdruck
- Kommunikationserleben und -verhalten

Dabei sollte erforscht werden, ob sich Veränderungen im Verlauf der Behandlung auf allen drei Ebenen zeigen und, wenn ja, ob Zusammenhänge in den Veränderungsentwicklungen untereinander bestehen. Ein zusätzliches Interesse galt dabei der Suche nach Möglichkeiten, die musiktherapeutische Zielebene 'Kontakt/Kommunikation' differenziert abzubilden, da das entsprechende Erfassungsinventar eingangs nur zwei Kategorien aufwies.

II. Inhaltliche Charakteristik und Durchführungsmerkmale der Musiktherapie

A Ansatz:

Den methodischen Schwerpunkt der Musiktherapie bildeten freie Improvisationen sowie strukturierende Improvisationsangebote, welche als Interventionen im Hinblick auf das soziale Gruppengeschehen eingesetzt wurden (vgl.: Esch, West 1996).
B Inhaltliche Gestaltung

In der Durchführung der Musiktherapie wurden folgende Spiel- und Improvisationsformen sowie therapeutische Verfahrensweisen eingesetzt:

- Freie Improvisationen
- Thematische Improvisationen zu diversen musikalischen Parametern: Rhythmus, Klang, Melodie, Lautstärke- und Tempodynamik
- Musikalische Selbstdarstellung (Solo)
- Imitations- und Dialogspiele (Duo, Rondo)
- Variations- und Rundspiele (Trio, Rondo)
- Wechsel- und Beziehungs improvisationen (Solo und Begleitung)
- Musikalische Rollenspiele
- Rezeptive Verfahrensweisen
- Verbale Reflexion des musiktherapeutischen Geschehens

C Ziele

Im folgenden werden kurz einige allgemeine Ziele der musiktherapeutischen Arbeit aufgeführt:

- Selbstwahrnehmung, Aktivierung, Kreativität
- Fremdwahrnehmung, Kontakt- und Dialogfähigkeit
- Kommunikations-, Beziehungs- und Gemeinschaftserfahrung
- Abgrenzungs-, Selbstbehauptungs-, Strukturierungs- und Integrationsprozesse mit Schwerpunkt im psychisch-emotionalen Handlungs- und Erlebensbereich

D Aufnahmekriterien

Zur Aufnahme in die Musiktherapie-Gruppe gelangten PatientInnen

- mit Psychosen aus dem schizophrenen Formenkreis nach abgeklungenener akuter Exazerbation
- in stationärer Behandlung
- im Alter von 20 bis 50 Jahren
- ohne deutlichere EP-Symptomatik
- mit Interesse an und Bereitschaft zur musiktherapeutischen Behandlung

E Organisation

- Gruppentherapie, halb-geschlossene Gruppe, 4-6 Personen
- Termine: 2 x wöchentlich, 50 Minuten
- Behandlungsdauer in der Musiktherapie: ca. 2 Monate
- Vor Aufnahme in die Musiktherapie-Gruppe erfolgen 2 Einzelsitzungen für Erstinterview, musikalische Anamnese, Einführung in die musiktherapeutische Arbeitsweise, Klärung des Behandlungssettings.
III. Teilnehmergruppe

A Stationäre Rahmenbedingungen


B Dropout-Rate

Insgesamt wurden 21 Ptn. sukzessiv in die Gruppe aufgenommen. 8 Ptn. schieden aus folgenden Gründen vorzeitig wieder aus:

- 2 Ptn. verließen die Musiktherapie-Gruppe wegen einer generellen Dekompensationsgefahr. Es kam zu einem Abbruch des gesamten Behandlungsprogramms und zur Verlegung auf eine geschlossene Station.
- Bei 2 Ptn. zeigten sich nach der ersten Gruppensitzung persönliche Vorbehalte gegen die Musiktherapie.
- 2 weitere Ptn. schieden wegen mangelnder Compliance wieder aus der Musiktherapie-Gruppe aus.
- Bei einem Pt. kam es kurz vor dem dritten Erhebungszeitpunkt zu einer disziplinarischen Entlassung.

C Charakteristika der Teilnehmergruppe

Es folgen einige Charakteristika der Ptn., welche im Auswertungsverfahren der Untersuchung erfasst wurden (n = 13):

<table>
<thead>
<tr>
<th>Tabelle 1: Soziodemographischer Hintergrund</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alter</strong></td>
</tr>
<tr>
<td><strong>Geschlecht</strong></td>
</tr>
<tr>
<td><strong>Familienstand</strong></td>
</tr>
<tr>
<td><strong>Wohnsituation</strong></td>
</tr>
<tr>
<td>Soziale Einbettung</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Schulabschluss</td>
</tr>
<tr>
<td>Berufsausbildung</td>
</tr>
<tr>
<td>Aktueller Arbeitsstatus:</td>
</tr>
</tbody>
</table>

### Tabelle 2: Krankheitsbezogene Merkmale

<table>
<thead>
<tr>
<th>ICD-10 Diagnose</th>
<th>Dauer der Erkrankung</th>
<th>Anz. stat. Vorbehandlg.</th>
<th>vom Patienten genannte Beschwerden und Probleme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoide Schizophrenie F 20.02</td>
<td>26 J.</td>
<td>14</td>
<td>Körperliche Schwäche, Versagenszustände, Kontaktprobleme</td>
</tr>
<tr>
<td>Paranoide Schizophrenie F 20.02</td>
<td>7 J.</td>
<td>5</td>
<td>Verfolgungsängste, Denkprobleme, Suizidgedanken, Schwächegefühl, Lebensbewältigungsprobleme</td>
</tr>
<tr>
<td>Hebephrene Schizophrenie F 20.1</td>
<td>2 J.</td>
<td>2</td>
<td>&quot;Zu viele Ideen, zu wenig Konzentration, zu viel Denken, zu wenig Körper-Geist-Gleichgewicht&quot;</td>
</tr>
<tr>
<td>Paranoide Schizophrenie F 20.0</td>
<td>2 J.</td>
<td>1</td>
<td>Stimmenhören, &quot;Probleme im Zwiegespräch mit Gott&quot;</td>
</tr>
<tr>
<td>Paranoide Schizophrenie F 20.02</td>
<td>19 J.</td>
<td>6</td>
<td>Kräftezusammenbruch, Verausgabung, Stimmenhören</td>
</tr>
<tr>
<td>Paranoide Schizophrenie F 20.03</td>
<td>9 J.</td>
<td>1</td>
<td>Angstzustände, Fremdheitsgefühl, berufliches Versagen</td>
</tr>
<tr>
<td>Schizomanische Störung F 25.0</td>
<td>9 J.</td>
<td>7</td>
<td>Unruhe, Gereiztheit, Außenseiterrolle, Kontaktprobleme, bes. zum weibl. Geschlecht</td>
</tr>
<tr>
<td>Schizophrenes Residuum F 20.5</td>
<td>3 J.</td>
<td>2</td>
<td>Konzentrationsprobleme, Abschottung, Passivität</td>
</tr>
<tr>
<td>Schizodepressive Psychose F 25.1</td>
<td>4 J.</td>
<td>1</td>
<td>Angstzustände, Depression, Suizidversuch</td>
</tr>
<tr>
<td>Schizophrenes Residuum F 20.5</td>
<td>6 J.</td>
<td>3</td>
<td>Konzentrationsstörungen, Job-Probleme, Vergesslichkeit, Schlafstörungen</td>
</tr>
<tr>
<td>Paranoide Schizophrenie F 20.02</td>
<td>6 J.</td>
<td>3</td>
<td>Schwäche, Kreislaufprobleme, Ängste</td>
</tr>
<tr>
<td>Paranoide Schizophrenie F 20.02</td>
<td>10 J.</td>
<td>2</td>
<td>Schlafprobleme, Ängste, Überlastung, Verfolgungsgedanken</td>
</tr>
<tr>
<td>Hebephrene Schizophrenie F 20.11</td>
<td>4 J.</td>
<td>4</td>
<td>Leistungsstörungen, &quot;seltsame Wahrnehmungen&quot;, Ruhelosigkeit</td>
</tr>
</tbody>
</table>
### Tabelle 3: Musikalische Erfahrungen

- in der Schule mit-musiziert: 8 Ptn.
- in der Vergangenheit kurzfristig Instrumental- oder Gesangsunterricht: 4 Ptn.
- autodidaktisch erworbene Kenntnisse: 8 Ptn.
- aktuelle musikalische Aktivitäten: 8 Ptn

### IV. Untersuchungsverfahren und Verlaufsplan

Folgende Dokumentations- und Einschätzungsverfahren kamen in der vorliegenden Untersuchung (u.a.) zur Anwendung:

1. Erstinterview (nach Tüpker 1992)
2. Musikalische Anamnese (nicht standardisiert, Plum 1994)
3. Pat.-Verlaufsboegen (Schirmer 1993)
4. Positive and Negative Syndrome Scale, PANSS (Kay et. al 1987)
5. Extrapyramidale Symptom-Skala, EPS (CIPS 1986)
6. Tonkassettenaufnahmen mit musikalischen Selbstporträts (Solo) der Ptn.
7. Musikerfassungsbogen, angelehnt an die "Musiktherapeutische Ausdrucks- und Kommunikationsskala" MAKS (Moreau 1996)

### Zu 1. und 2.
Vor Aufnahme in die Musiktherapie-Gruppe erhielten die Ptn. in 2 Einzelsitzungen die Gelegenheit, die musiktherapeutische Arbeitsweise kennenzulernen. Gleichzeitig wurden in diesen Sitzungen das Erstinterview und die musikalische Anamnese durchgeführt, ein 'Solo' geprobt sowie das weitere Vorgehen in der Begleituntersuchung erläutert.

### Zu 3.
Von dem Pat.-Verlaufsboegen wurden zwei Kategorien ausgewählt, welche das Kontaktverhalten betreffen:

- Kontakte verbal / gestisch,
- Musikalische Kontakte, Aktionen, Interaktionen

Zu diesen Kategorien wurden im Anschluss an jede Therapiesitzung vom behandelnden Musiktherapeuten für jeden Ptn. frei formulierte Eintragungen vorgenommen.

### Zu 4. und 5.
Zu drei Untersuchungszeitpunkten, und zwar der 1., 7. und 15. Sitzung, erfolgte die Erhebung des psychopathologischen Befundes (PANSS) sowie der EP-Symptomatik (EPS) durch die
behandelnden StationsärztInnen.

Zu 6.
Zu diesen drei Erhebungszeitpunkten erfolgte auch die Dokumentation des musikalischen Selbstporträts (Solo), gespielt auf dem Standardinstrument Marimbaphon. Dies geschah im Rahmen der Musiktherapie als "Stunde mit musikalischen Solos und verbalem Feedback". Die Spielaufforderung zur musikalischen Selbstdarstellung lautete: "Spielen Sie ein musikalisches Selbstporträt von etwa 3 Minuten Dauer. Spielen Sie so, dass etwas Typisches Ihrer Person deutlich und für die ZuhörerInnen erkennbar wird." Die Anweisung für die ZuhörerInnen lautete: "Hören Sie der Musik gut zu. Achten Sie darauf, wie das Spiel auf Sie wirkt und was die Musik in Ihnen auslöst. Versuchen Sie sich ein charakteristisches Merkmal einzuprägen und in Verbindung mit dem Spieler zu bringen."

Zu 7.
Die "Einschätzung" der Solomusik erfolgte nach Abschluss der Musiktherapie durch drei unabhängige Rater (MusiktherapiestudentInnen) mittels des Musikerfassungsbogens nach MAKS.

Der folgende Plan gibt eine Übersicht über den Studienverlauf und die eingesetzten Untersuchungsverfahren:

### Tabelle 4: Untersuchungsplan

<table>
<thead>
<tr>
<th>Woche</th>
<th>Erst-Interview</th>
<th>Anamnese</th>
<th>Verlaufs-Bogen</th>
<th>Solo-Musik-Aufnahme</th>
<th>PANSS</th>
<th>EPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1. Einzelsitzung</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Einzelsitzung</td>
<td></td>
<td>X</td>
<td>X(Probe)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1. Gruppensitzung</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Gruppensitzung</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-4</td>
<td>3.-6. Gruppensitzung</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>7. Gruppensitzung</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Gruppensitzung</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-8</td>
<td>9.-14. Gruppensitzung</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>15. Gruppensitzung</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16. Gruppensitzung</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

weiter (Seite 2)
Entwicklung des Kommunikationsverhaltens, des improvisatorischen Spielausdrucks und der Psychopathologie im Verlauf einer Gruppen-Musiktherapie mit schizophrenen PatientInnen

V. Ergebnisse

A Entwicklung der psychopathologischen Verfassung, einschließlich der extrapyramidalen Symptomatik

1. EP-Symptom-Skala (EPS)
Für die 13 Ptn., die in der Auswertung der Untersuchung berücksichtigt wurden, zeigten sich keine wesentlichen EP-Nebenwirkungen, welche die musikalische Spiel- und Ausdrucksfähigkeit hätten beeinflussen können (Mittelwerte in der 1., 7, 15. Sitzung: 0.4, 0.3, 0.2).

2. Positive and Negative Syndrome Scale (PANSS)
In Abbildung 1 zeichnet sich eine nur leicht rückläufige Entwicklung ab. Die intraindividuellen Veränderungen bewegen sich im Durchschnitt nur in einem schmalen Bereich der anfangs gegebenen interindividuellen Variation. (Für die Positiv-, die Negativ- und die Global-Skala liegen die Werte V/r unter 0,1.)
Diese geringe Bewegung ist (zum Teil) erklärbar durch die Behandlungsphase, in der die Ptn. sich befinden: die akute Symptomatik ist weitgehend abgeklungen, vorherrschend sind sog. Negativsymptome, die sich meist nur zäh ändern. Auch bei der Betrachtung individueller Verläufe zeigt sich die o.g. Entwicklung, jedoch wird hier deutlich, dass sich die Ptn. auf unterschiedlichen Niveaus der psychopathologischen Auslenkung bewegen (s. Abb. 2 und Abb. 3).
B Entwicklung des improvisatorischen Spielausdrucks

1. "Rating" der musikalischen Selbstporträts
Die Ausdruckskategorien 'Formgestaltung', 'Variation', 'Spannung', 'Spielfluss' und 'Ausdrucksqualität' werden in 5 bzw. 7 Stufen durch inhaltliche Charakterisierung untergliedert.

2. Entwicklung des Spielausdrucks
Abb. 4 stellt pro Beschreibungskategorie den Verlauf der Mittelwertkurve (n = 13) über die 3 Messzeitpunkte dar (1., 7., 15. Sitzung). Die Veränderungen sind nicht sehr eindrucksvoll.
Bei einer Betrachtung der individuellen Verläufe (s. z.B. Abb. 5 und 6) zeigen sich dagegen sehr unterschiedliche, bewegte, zum Teil gegenläufige Entwicklungen. Offensichtlich führt die Zusammenfassung zu Mittelwertkurven zu einem nivellierten Bild. Über Gründe für diese individuell unterschiedlichen, zum Teil sprunghaft wirkenden Verläufe sowie über deren Wertigkeit kann - zunächst - keine Aussage gemacht werden. Wichtig erscheint jedoch, dass sich trotz einer relativ geringen Veränderung der psychopathologischen Verfassung im musikalischen Ausdruck ein differenziertes und bewegungsreiches Bild entfalten kann. (Für die Variable 'Formgestaltung' gilt z.B.: V/r = 0,3.)
Abb. 6: Entwicklung der Werte der MAKS-Variablen bei Patient S
C Entwicklung des Kontaktverhaltens

1. Auswertungsmethodik
Nach Abschluss der Dokumentations- und Erhebungsphase wurden die frei formulierten Eintragungen zu den beiden Kategorien des Schirmer-Bogens (s. Kap. IV: Untersuchungsverfahren) analysiert und gruppiert. Dabei ließen sich versuchsweise für die Kategorie 'musikalische Kontakte, Aktionen, Interaktionen' eine 5-stufige Skala und für die Kategorie 'Kontakte verbal/gestisch' eine 4-stufige Skala entwickeln (s. Abb. 7; Stufe 5 im 'verbal/gestischen Bereich' ist nachträglich konstruiert in Analogie zu Stufe 5 im musikalischen Bereich).

Zur Darstellung der Patientenentwicklung wurden die Beobachtungen pro Pt. und Sitzung in diesen Skalen eingeordnet.

<table>
<thead>
<tr>
<th>Kontakte verbal / gestisch</th>
<th>Musikalische Kontakte, Aktionen, Interaktionen</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Zurückgezogen, selbstbezogen, isoliertaktiv abgegrenzt</td>
<td>I Selbstbezogen, isoliert, abgegrenzt, aber auch ausprobierendes und entdeckendes Spiel &quot;Null-Kontakt&quot;</td>
</tr>
<tr>
<td>II Lässt sich gelegentlich 'ansprechen', ist jedoch nur passiv einbezogen</td>
<td>II Hintergrunduntermalung, passiv miteinbezogen Schwanken zwischen Mitspiel und isoliertem, eigenem freiem Spiel (auch: Kontaktversuche stören) &quot;Rand-Kontakt&quot;</td>
</tr>
<tr>
<td>III Eingehen auf Kontaktversuche anderer mit eigenen aktiven Anteilen</td>
<td>III Re-Aktionen, Einstimmung auf Spielpartner, Eingehen auf Kontaktversuche anderer (Solo und Begleitung, Dialog) &quot;Dialog-Kontakt&quot;</td>
</tr>
</tbody>
</table>
IV Aktive Kontakt-Initiationen,  
- zum Therapeuten  
- zu einem oder mehreren Mitpatienten

IV Sucht und versucht Kontakte zu anderen, startet aktiv Interaktionen, Dialoge und Zusammenspiel mit Therapeuten oder Mitpatienten "Initiativ-Kontakt"

(V) Greift im Gruppengespräch Themen auf, ist interessiert, aktiv beteiligt.

V Zeigt Integriertes Zusammenspiel, einfühlsmes Mitspiel, spielt im gemeinsamen Gruppenrhythmus, fühlt sich ein ins Gesamtklangbild "Gemeinsamkeits-Erfahrung" "Gruppen-Kontakt"

Abb. 7: Stufen des Kontaktverhaltens, konstruiert aus den 'freien' Eintragungen in den 'Schirmer-Bogen'

2. Darstellung des Verlaufs
Die Abbildungen 8 und 9 zeigen die Veränderungen in den beiden Bereichen des Kontaktverhaltens, summiert über alle 13 Ptn. im Verlauf der Therapie.

Abb. 8 Entwicklung des musikalischen Kontaktverhaltens während der Therapie (gemittelt über 13 Ptn.)
In den beiden Graphiken zeichnet sich eindrucksmäßig über die Gesamtdauer der Therapie hin ein Anstieg der Werte ab, deutlicher ausgeprägt in Abbildung 9. Die orientierende (konservative) Prüfung auf monoton aufsteigenden Trend mit einer Variante des Foster-Stuart-Tests (Lienert 1978) erbrachte für das verbal/gest. Kontaktverhalten ein signifikantes Ergebnis (p=0,035), nicht dagegen für das "musikal.' Kontaktverhalten (p=0,401).

Betrachtet man - wie schon bei der PANSS und bei der MAKS - die Entwicklung bei den Ptn. S. und L. über die Therapiesitzungen 1, 7 und 15 hin (s, Abb. 10 und 11), so zeigt sich wiederum, dass sich hinter der Gruppenkurve sehr unterschiedliche individuelle Verläufe verbergen. (Für die Variable 'verb./g.K' und 'mus.K.' liegt der Werte V/r jeweils nahe bei 0,5.)
Abb. 10: Entwicklung des verbal / gestischen und des musikalischen Kontaktverhaltens bei Patient S.

Abb. 11: Entwicklung des verbal/gestischen und des musikalischen Kontaktverhaltens bei Patientin L.

Bei beiden Ptn. findet sich - deutlicher als im Gruppenmittel - in der Kategorie 'Musikalische Kontakte' ein kontinuierlicher Anstieg der Werte in der therapeutisch gewünschten Richtung.

VI Diskussion

Bei der vorliegenden Untersuchung handelt es sich um eine explorative, praxisbegleitende Studie mit einer Reihe von methodischen Einschränkungen. So ließ sich z.B. keine stationäre Wartegruppe organisieren; die Ptn. nahmen in unterschiedlichem Ausmaß an den übrigen Therapien auf der Station teil. Dargestellt werden - auf rein deskriptivem Niveau - erste Ergebnisse; die Auswertung ist noch nicht abgeschlossen.


**Literatur**


Unser herzlicher Dank gilt allen Mitarbeitern der (damaligen) 'Station P4', die durch ihre Kooperation dazu beigetragen haben, das Untersuchungsprojekt durchzuführen und in den laufenden Therapie- und Stationsalltag zu integrieren.
Kontaktadresse:

F.J. Plum  
Rheinische Kliniken Essen  
Musiktherapie der Klinik für Psychiatrie und Psychotherapie  
Universität GH Essen  
Virchowstr. 174  
45147 Essen

>>>zurück (Seite 2)
Research News from Austria
Christian Gold

Christian Gold is a PhD student at Aalborg University. A short summary of this research project can be found here.

Decades ago, Vienna was one of the places where the cradles of European music therapy stood. For a long time, the Viennese model of music therapy was associated mainly with one name, Alfred Schmoelz, who was a father figure of music therapy there. Although both training and clinical practice continued to be elaborated in the years after Schmoelz's death, there has been a lack of Austrian research and publications for quite some time. Recently, however, there have been new developments. It looks as if Austrian music therapy is awakening from "the Sleeping Beauty's slumber", as the following examples illustrate.

Current multi-centre study on the effectiveness of long-term individual music therapy with mentally ill children and adolescents

After the research design of the study has been successfully evaluated in a pilot study, the data collection for the largest outcome study on music therapy with mentally ill children and adolescents so far is now on the way. To accomplish a large enough sample, several institutions were asked for their participation. The following institutions have agreed upon their participation up to now: Children's Social Services St. Martin, Klosterneuburg - Kindergarten Stadtschlaining - Mobile Special Educational Service "Rettet das Kind" Burgenland, Eisenstadt - Neurological Hospital Rosenhügel, Wien - Out-patient Clinic "Sonnenschein", St. Pölten - Out-patient Clinic Märzstr. 122 "Am Himmel", Wien - Out-Patient Therapy Clinic "Haus der Zuversicht" Waidhofen/Thaya - Out-Patient Therapy Clinic Mistelbach - Primary School Oberschützen - Primary School Pinkafeld - Private Practice Barbara Gabriel - Private Practice Christian Gold - Private Practice Regina Halmer-Stein - Secondary School Oberschützen - Special Educational Centre Hinterbrühl - Special School Paulusgasse, Wien - Special School Schwarzingergasse, Wien.

The project is still open for additional contributors.

The results of the pilot study are going to be presented at the Conference of the Society for

Follow-up study on specific and unspecific working factors of music therapy with psychosomatic patients presented in Ulm

Barbara Danner’s newly completed diploma thesis "Specific and unspecific working factors of music therapy - a follow-up survey among psychosomatic patients of a psychiatric hospital" was presented at the Workshop for Music Therapy Basic Research in Ulm, Germany on 09.02.2001, by the author and her supervisor, Dorothea Oberegelsbacher.

71 of 194 former patients who had received in-patient group music therapy completed a questionnaire with 50 items concerning subjective attitudes toward their music therapy. A principal components analysis yielded a model of three specific and two unspecific factors. The first factor, which accounted for 42% of the variance, was named "presentation and communication through music" and was regarded as music therapy specific. The other two music therapy specific factors were named "active offer of relationship through music" and "music therapeutic working through and transformation". The two unspecific factors were named "function of the group per se" and "therapist’s esteeming behaviour".

The discussion focused largely on the limitations of the study. Horst Kaechele pointed out that the proportion of non-responders should usually not be greater than 30%. The value of the results could be much improved if further knowledge about the non-responders could be gained. However, the examination of specific and unspecific factors in music therapy is an important issue. The presented study is a valuable step forward on this task and may provide a basis for the development of future research.
The website itself is being renovated as we listen to what you have been telling us through e mails and contacts at conferences. Research and Practice News is now one combined e magazine "Music therapy Today". Send in your news and details of your projects. David Aldridge has taken over the Chair of Publications for the World Federation of Music Therapy, so this is the site for you to get your practice and research seen by an international readership. The European Music Therapy Conference in Naples proved to be a watershed for new activities. It was clear in the conference that the standard of music therapy presentation is being raised, and that research in particular is blossoming. I hope that colleagues will be inspired to try out their ideas on these pages. For those wanting to get their ideas circulated, then this website is one possible medium. The advantage is that you can try out your idea here and your peers can offer their commentaries. See the papers by Clinical Practice David Aldridge (2001) "Music therapy and neurological rehabilitation: Recognition and the performed body in an ecological niche". Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net German version: David Aldridge (2001) "Musiktherapie und neurologische Rehabilitation: Erkenntnis und der gestaltete Körper in einer ökologischen Nische". Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net David Aldridge (2001) "The creative arts therapies in the treatment of neuro-degenerative illness". Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net Research Showcase Karen Radbruch (2001) "Music therapy in the rehabilitation of children with cochlea implant (CI)". Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net German version: Karen Radbruch (2001) "Musiktherapie innerhalb der Rehabilitation von Kindern mit Cochlear Implant (CI)". Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net Teaching Forum Isabelle Frohne-Hagermann (2001) "Aesthetic Perspectives in Music Therapy", Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net German version: Isabelle Frohne-Hagermann (2001) "Ästhetische Dimensionen der Musiktherapie", Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net Research Methods Christine Jakabos und Peter Petersen (2001) "Art therapy in oncology: Results of a literature research" Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net German version: Christine Jakabos und Peter Petersen (2001) "Kunsttherapie in der Onkologie: Ergebnisse einer Literaturstudie". Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net Citing electronic articles Articles published on the web may be cited as publications. For example; Radbruch, K (2001). Music therapy in rehabilitation for children with cochlea implant. Music Therapy Today (online), November, University Witten Herdecke: Witten. Available at www.musictherapyworld.net I include arts therapy papers in the website because we all face as creative arts therapists the challenge of research and practicing in a medium that demands we reconcile both the arts and sciences. On the next Info CD ROM III, you will also find a PhD thesis by Sue Hacking related to the assessment of art therapy products. The next Info CD ROM IV is planned for publication at the 10th World Congress of Music Therapy in Oxford. On this planned CD ROM IV you will find a collection of articles, the proceedings of the European Conference from Naples in April 2001, our updated databases for specific music therapy interests and a sample of music therapy videos for teaching. If you want your work to be included the send it to Dr Jörg Fachner: joergf@uni-wh.de Remember to look in our archive of collected papers for interesting material and in the video archive to download material. If you
are a teacher discuss with us about including your material in the archive. The European Music Therapy Conference in Naples also discussed the acceptance of music therapy in Europe and you can read comments from the Round Table. Book review editor Annemiek Vink We are starting a database of music therapy books complete with URL links to the publishers so that you can order books directly or via your electronic book site. We already have information about music therapy books, and you can of course find titles of books in our database. This does not bring to awareness the many new books being produced in the field, so we hope that with a book reviews editor and a structured database we can inform you of what is going on in the worlds of music therapy, the arts therapies, musicology, music-ethnology and music education. Please note we are NOT a commercial organisation and do not act as booksellers. This is a database of new published material for you to look up and find what you want. For authors and publishers wanting their work to appear in this database please send two copies of the publication to Annemiek Vink. If you as a practitioner, teacher or researcher want to bring our attention to something really worthwhile reading then let us know. a.c.vink@planet.nl

Dissertations database
Annemiek Vink At the European music therapy conference in Naples, students were asking for dissertations to be put into a database as a learning resource. We have the abstracts from various teaching institutes in the music therapy database already. What we plan to do is to include full text versions of dissertations in a dissertation database. Annemiek Vink has also been suggesting the same initiative as she is aware of interesting work that students produce for their diploma theses or masters theses. So, we are giving students and their teachers the opportunity to make this work available for other colleagues. The important part of this work is that the material will be presented in its original language. Unfortunately, we are not at the stage where we can translate vast amounts of material. For further information please contact Annemiek Vink. a.c.vink@planet.nl

Annemiek Vink has been trained as a psychologist. She works as a music therapy teacher at the conservatory in Enschede, the Netherlands and is a board member of the "Stichting Muziektherapie". Also she is working on a PhD-research studying the effect of music therapy reducing agitation in demented elderly. Supervision: Prof. Dr. J.P.J. Slaets of the University of Groningen (Netherlands) and Prof. Dr. David Aldridge (University of Witten-Herdecke, Germany).
Music therapy and neurological rehabilitation: Recognition and the performed body in an ecological niche.

David Aldridge

Traumatic brain injury is a major public health problem and an important challenge for neurological rehabilitation (Mazaux and Richer, 1998). Neuro-degenerative diseases are also an enormous public health problem (Brookmeyer et al., 1998; Hendrie et al., 1995). Interventions that can even modestly offer recovery or relief will have a major public health impact. We see a common core of loss of bodily integrity, failed cognitive competence and the demise of emotional coherence. To this we must add the potential for social isolation that deterioration or injury brings, and isolation is the road to despair. We do not suffer alone; these losses have an impact upon family and social life (Aldridge, 1998).

While there are numerous projects aimed at finding medical relief of suffering and the treatment of injury and disease, we are reminded that these problems are also illnesses. Behaviour is influenced. We are challenged as a society that people within our midst are suffering and it is our responsibility within the delivery of health care to meet that challenge with appropriate responses. A major confrontation for patients is that they awake the deepest fears of a consumer success-oriented society. Decline, physical and mental, is not readily faced within communities that expect youthful appearance, worldly success and physical ability as the outer signs of acceptable personhood (Aldridge, 2000b). Any adjuvant therapies that will address these factors of isolation and acceptance will offer a significant part of a modern treatment strategy in neurological rehabilitation. The expressive arts therapies are to be considered as a part of this strategy.

In this paper I will discuss the difficulties faced by patients in neurological rehabilitation. Essentially we are talking about people confronted by minds and bodies that are failing to perform as previously expected. This situation is for them and their families distressing (Gervasio and Kreutzer, 1997). The expectations will be that those persons will be indeed re-
habilitated; brought back to perform their previous habits or, from the mediaeval root *habilitare*, rendered fit again. Fit is a useful metaphor in this context, as I want to use the word as “fit” in an ecological sense. Our sensory organization must fit into the ecology of the person and the person in his or her environment (Aldridge, 2000b).

How experience is unified and organized is a central question. Behavioural integration is the key to experiential unity that opens the lock of mutual performance necessary for relationship. The experiencing person is not simply a set of brain activities but an embodied mind actively engaged with an environment, the ecology of events and ideas that we call consciousness (Aldridge, 2000b). We experience ourselves as active embodied beings intimately connected with the world as we act upon the world. And we too are acted upon. Habit is necessary as it leads to an economy of consciousness, that “the process of habit formation is a sinking down of knowledge to less conscious and more archaic levels” (Bateson 1978 p114). We do not always need to know how we perceive, simply what we perceive. In the process of rehabilitation, we must resurrect these habits to achieve the next levels of consciousness including cognition. Thus the return of gesture, as iconic communication, will be a singular step forward along the road to recovery.

What I will be proposing is that movements are generative of complete sequences of interactions that promote cognition. Perception and action are interwoven as activities. In the network of pre-motor actions, there is a repertoire of possible actions and action must be selected. Attention is necessary to perform an action. Performance focuses attention, thus the emphasis on music therapy as performance; a setting of musical activity that promotes attention from which meaningful coordinated sounds can be performed. In this sense, memory is a state of consciousness brought about by movement and integral to the developmental process.

Performance, movement in a temporal and relational context, will be a central concept at the centre of my thesis. Indeed, as I have written elsewhere, my contention is that we are improvised performed beings; that is, we realize ourselves in the world, mentally, physically and socially as performances in and of time (Aldridge, 1991, 1999). What we see in the process of the neurological rehabilitation is a restriction in performance of movement, of communication, of thinking and, for some, being a whole person. My contention is that music therapy promotes performance and retains residual performance as long as possible.

Memory is crucial to the process of human development, vital in the regaining cognition and central to our concerns about neuro-degenerative
disease. The foundation of memory is the coupling of events in time as an adjunct to bodily action. Through movement we have that tension of consciousness we call memory. Through memory we transcend our abilities beyond behavioural responses to those of an individual identity brought into dialogue. We are active in the world and perform that world. In the development of performance we move from habitual movements to those of choice, this is the development of consciousness and occurs in stages. Indeed, we recognise the world. Recognition is not simply the act of recognising others, but re-cognising ourselves in the world with others. Cognition, in this sense, is a achieved as an activity through dialogue beyond habit. We may wish to consider re-cognition as a sub-set of re-habilitation. And recognition is a dynamic process of adaptive relationship. We modify ourselves and others, as they in turn mutually modify us and themselves, through interaction. Even in the severely disabled, the possibility of action remains.

The videotaped examples that I will show you are taken from therapy sessions where there has been severe neurological damage, where there is a recognized communication disorder, or from therapy with elderly patients suffering with various dementias. In most of these examples I will be showing performances where communication abilities have been assessed as being severely impaired. Indeed, in many of the examples patients cannot speak. But my contention is that they can, and do, communicate even without speech. Of course we have the concept of non-verbal communication. What I intend to show are the elements of that communication and the way in which such components prepare the way for verbal communication.

Furthermore, I intend to show that some of the symptoms that we see as of failing performance are, in the context of a performative paradigm, an attempt to achieve communication and an attempt to achieve cognition. The first time that I was alerted to this is in a small study that we completed with developmentally-delayed children (Aldridge, 1996). After music therapy, all the children scored on the cognitive ability sub-sections of a child development rating scale, whereas some had previously failed to score. On looking through the tests, the statistical interpretation of repeated measures showed an improvement in relationship scores, in hearing and hand-eye coordination. Music therapy is about these elements; the therapeutic relationship, within a specific hearing/listening environment involving the active performance of sounds using integrated movements, which promote development.

Essentially I will be arguing that the basis of human communication is musical. We know that the essential properties of human understanding regarding verbal communication are speech prosodics; tempo, timbre,
volume and pitch. This is how we interpret the meaning of what people say to us, particularly in regard to emotional content. At the centre of recovery in rehabilitation is the problem of timing. Timing, I hardly need to add, is a central feature of musical performance (Aldridge, 1994).

The problem remains of how do we know that the other person is communicating or attempting to communicate? Again I return to our work with children where the coordination of hand and eye movements as gesture, in a listening environment of musical performance, where central to achieving communication. We also know from studies in child development and the study of communication in primates that gesture as a foundation of communicative ability. Gesture as a communicative essential brings, however, a dilemma. While we can see and hear what others do, and this is important for understanding, it is precisely the elements necessary for gesturing that begin to fail in neuro-degenerative diseases or are misplaced after a neurological insult. Timing is lost and movements fail to be coordinated, thus communication fails. However, we know from previous studies, that music therapy has the potential to promote coordination such that communication is achieved (Aldridge, 2000a).

**Breath, rhythm and consciousness**

In an intensive care situation, it appears that patients lose their own agency, the ability to perform intentional acts. That intentionality necessary for life becomes disoriented in time and space; the rhythm of breathing and consciousness is lost. For patients seeking to orient themselves then the basic rhythmic context of their own breathing is the focus for that re-orientation. Intentionality in human behaviour may occur even when consciousness appears to be absent, there are still vital rhythmic processes present.

We can speculate that the various body rhythms have become disassociated in such comatose states. The question remains then of how those behaviours can be integrated and where is the seat of such integration? My answer would be that it is breathing that provides the fundament of human communication, and it is the organisation of breathing, as performed in singing, that is the major agent in therapeutic recovery.

Central to the act of breathing, and in terms so healing, breathing together, is the concept of performance in the subjective now. The coordination of human activity that lends itself to the coherence that we experience of being healed is dependent upon a temporal concept. Time is structured and breath is the scaffolding of time in which the present is constructed.

The construction in time, that we call now, when extended, is the basis of cognition. That is how music therapy works, it offers a temporal structure for events that facilitates cognition.

At the heart of this temporal coherence is the rhythm of breathing. Through the control of breathing we achieve coherence. For those disorientated in time, then they become oriented through that non-material activity of breathing, although the material necessity of gaseous exchange is present. This is why some scientific approaches appear to be coarse as they concentrate on the coarse elements of breath not on the subtle qualities, and why some of us refer to the fact that patterning is what lies behind the explication of the pattern.

Time and 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; that is, intention. 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. Rhythm demands intention.

Patients in rehabilitation are often prisoners of mechanical time. They have not a chronic illness but a kairotic illness. While the various physiological elements may be in place, initiation of those activities to promote coherence cannot take place, Acts cannot be brought into being and therefore purposes remain uncompleted. In this way, being in a coma is not something that makes sense, it is something that no longer makes time. Sensory abilities may well be present but they have no context of coherence. 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. Mentation for the coma patient is a kairotic process not solely understandable as chronology. Dementia is the decoupling in kairotic time of physiological events. Achieving consciousness then is becoming in time, and this is facilitated by the intentional breath of the healer. In this way, physiological events and psychological events are woven together into that fabric we know as memory. The warp of which is time.

Maintaining dialogue

Communication is based upon linking behaviours together, our own and those of others. This dialogue, which constitutes a sense of coherence to what we are as “selves”, is narrative in nature. It is personal and social. If this breaks down then we lose a sense of meaning for ourselves, and we lose
meaning as a person in a social context. We lose the meaning of what we do and what we do with others. What we do literally makes no sense; this is the process of dementia.

The maintenance of meaning on an everyday level demands a sense of coherence between events (Crossley, 2000). When disorder happens, then coherence must be rebuilt. Music therapy is one way of establishing a short-term coherence and thereby of re-establishing identity (Aldridge, 1989). Meaning is an activity; it demands a temporal structure of connectivity and relationship between events that we call consciousness (Aldridge, 2000b). Trauma, whatever its sources, disrupts this coherence and the horizon of time is limited.

A subjective sense of self is dynamic and multi-faceted composed of interactions within the individual and with others (Lysaker and Lysaker, 2001). Thus, the existence of self is dependent upon a rich context of dialogical interaction. This is what fails in dementia, and it fails progressively. My contention is that we may speak of dialogic-degenerative diseases as much as neuro-degenerative diseases. The restricted communicative environments in which people find themselves further compound the stigma of dementia, and indeed of chronic illness. A therapeutic environment will necessarily promote a rich diversity of dialogic possibilities sensitive to a broad range communicative possibilities; therefore, the range of creative arts therapies including music therapy, art therapy and dance/movement therapy.

Through dialogue we achieve the social. While many authors predicate dialogue on language, my argument is that dialogue is performance like music. It is common play together that overcomes our differences and promotes plurality. Gurevitch (Gurevitch, 2000), writing about dialogue, emphasises that when dialogue breaks down it does so in silence. However, for musical communication, the very core of performance is the tension between sound and silence. Gurevitch writes,

“..the possibility of dialogue as poetics where the plurality of sociality is informed by the breaks of conversation” (p247).

I would reinterpret this as

“..the possibility of dialogue as performance where the plurality of sociality is informed by the pauses of play”

Silence, is the basis for the meaning of what becomes evident. What makes sound and silence coherent is a sense of time. When timing fails then we lose coherence. Melody then will become the mutual topic of communication and provide a state of closure for the discourse; it is achieved in the betweeness of the participants and is the manifestation of the social. If language influences
the self that we present, then certain linguistic forms will influence the discourse that we use. For our patients with a severely curtailed repertoire of linguistic resources, then we are challenged to provide them with a rich communicative repertoire, that is, musical. An enhance repertoire of music resources will promote a variety of potential discourses.

What music therapy offers for the patient is a voice from out of this silence. I am using voice in a broad sense here; as utterance, as gesture, as beat on an instrument, as tone. It is through voicing ourselves that we achieve recognition by others and that we recognize the presence of others. I use “re-cognise” deliberately here as pointing to the achievement of cognition. But we need a site for these voices to perform; these are the dialogues in context. When we limit the sites of these performances then we impoverish the possible dialogues and restrict the ability of patients to achieve their “selves”. Dialogue then is existential and necessary for the achievement of health in the sense of becoming whole (Aldridge, 2000b).

Dialogue is not simply given, it has to be achieved and negotiated. And meanings within this dialogue are never forced. We are constantly involved in interpreting the meaning of what others are doing. We do this constantly in clinical practice, first in diagnosis as understanding what the problem is, and then in understanding what is happening through the course of the therapy. These negotiated meanings are fragile, and performance has to be maintained in its mutuality. While we talk of degenerative disease, we must also be aware of the adequacy of our own performative abilities in the context of our therapeutic dialogues such that we are adequate in our performance to meet the needs of others. This performance is based upon what we as practitioners bring to the dialogue as an ability to exist in time; the expressions on our faces, the postures of our bodies, the repertoire of our utterances, the prosodics of speech.

When dialogue fails then we have alienation and despair (Aldridge, 1998, 2000b). The maintenance of the self degenerates through isolation, as I mentioned earlier we have the potential for dialogic degenerative disease. Patients may be forced into a silence that they have no possibilities to neither transform nor structure, they are banished from the social to an isolated and degenerated self.

To resume dialogue however is to achieve reciprocal recognition (Gurevitch, 2001). We invite communication and require the “yes” of participation. This is exactly what happens in music therapy, there is an invitation to participate. It is in the performance of both parties that we have the dynamics of interaction. To achieve plurality, we need two voices (Gurevitch, 2001).
We have then a shift from the self to the other, the act of mutual recognition. Achieving cognition is not simply a personal act. It is social.

Rehabilitation and the family; a communicative context

In addition, we do not live our lives alone, and that means we have to enter into dialogue with others around us. That is what communication is for. Communication is not located in one person alone, we have to establish communicative relationships. Music therapy is a prime example of how, when speech fails, we establish meaningful communication and interpret what the needs of the other are. This is essentially an hermeneutic; the interpretation of meaning and is not restricted to a verbal competence. For those seemingly with damaged capacities, we can retain significant communication such they can express themselves and such that we can understand each other.

In Gervasio and Kreutzer’s study (Gervasio and Kreutzer, 1997) describing the psychological distress experienced by live-in relatives of people with traumatic brain injury comparing the distress of spouses with that of other relatives, family caregivers of people felt alienated, isolated, overwhelmed, and mentally preoccupied. Spouses experienced more distress than parents. Bos (Bos, 1997) has suggested that coma stimulation as a treatment in which a health care professional or a patient's family member systematically applies stimulation to one or more of the patient's five senses for the purpose of increasing patient responsiveness. Furthering this field of stimulation and responsiveness, but concentrating on auditory stimulation, music, the voices of family members and friends have been used as interventions (Jones et al., 1994; Seibert et al., 2000). My argument is that music therapy incorporates these elements of relationship, sensory stimulation and appropriate response in a systematic manner based upon the developing communicative needs of the patient as consciousness changes and cognition is achieved (Aldridge, 1991; Aldridge et al., 1990). Communication, in this perspective, is not located within the individual but is an interpersonal phenomenon.

Utterance

When the means of producing language is in the process of being lost then we become aware of the restricted means of presenting self. Music therapy is a means of producing communication and it is based on gesture, which is the basis of communication in a variety of species. We know that communication without language is possible in primates (Bond and Corner, 2001), for example. An essential feature of gesture is the concept of “utterance”. We do make sounds outside the range of lexical language. Utterances are linked together in a grammatical form such
that meaning is understood. This linking together as grammatical form in time is the basis of song and we are able to understand the general meanings of songs sung in other languages.

Structure, as form, is a way of schematising experience and this is the way that we learn to think. We achieve cognition through linking together events in time; it is the achievement of memory. We link sounds together into phrases, and this is the basis of musical meaning in that sounds begin to function as music when we discern a structure between the tones. Utterances then are a positive sign of the producer attempting regain cognition, to mentate out of the de-mentation by providing an expressive cue to an underlying temporal dynamic. The task of the other person present, and certainly the music therapist, is to recognise this temporal dynamic and structure a mutual participatory performance.

A quality of utterances, and many gestures, is that they are spontaneously expressive. With demented patients, the challenge of therapy is to move from the spontaneously expressive to the performatively reflexive utterance that is intentional. It is a mutual shared temporal dynamic that offers a structure for spontaneity, which allows repetition within musical form, and thereby focuses attention and the possibility of regulation. As with all acts there is a constitutional aspect – what this event means-and a regulative aspect – what is to done next as a meaningful response. Thus utterances become articulate.

A fundamental property of mental ability is that is explicated in verbal and musical expressions, gestures and bodily expressions. As we have seen earlier, understanding is achieved through performance. The body is active in the world to open up the world and belongs to the world. Illness becomes a restriction of this bodily presence and thus restricts both presence in the world and understanding (Svenaeus, 2000). The challenge of music therapy is the challenge that we all face, how to establish the pattern of meaning.

At the heart of this understanding is time. Time is the how of events being organized and is the attribution of meaning to change (Tabboni, 2001). How we perceive time is multi-faceted, it is part of our personality and part of our culture and achieved in our relationships. We have various modes of understanding time and in neuro-degenerative diseases these are restricted. In Parkinson’s disease we have a disruption of time and its expression in emotion (Kremer and Starkstein, 2000) and movement (Thaut and McIntosh, 1999), in Alzheimer’s disease we have a loss of memory and of fluency (Aldridge and Aldridge, 1992; Aldridge and Brandt, 1991). The phenomenon of “sundowning” in dementia patients is a physiological change where that time structure is lost that coordinates
activity and temperature (Volcer et al., 2001).

The coupling of the neural system, the musculo skeletal system and the environment demands a coordination of temporal dynamics. There are scale relationships of time dependent upon biological events; muscular, cellular planetary, galactic. Behaviour is temporally structured and it is in the organization of time that we synchronize our communication. Anticipation of events and coordinating responses demands a temporal dynamics based upon attention (Keijzer, 1998). Anticipation of events is central to playing rhythm with another person and we see this in the mutual playing of improvised musical playing where even severely disabled patients have the ability to anticipate events and coordinate their behaviour within a context of a flexible temporal dynamic. We are speaking here of musical time that I itself is flexible as performed, not the chronological time of a machine.

**Gesture**

In therapy we have a performed dialogue. The body is central for interaction. We perform most of our action in daily life without reflecting on how we do it. Everyday skills are the basis of the knowledge that we need to perform our lives. Knowledge is done. It is based on interaction with others and is the background from which we achieve understanding of what others are doing. Therefore, the performance possibilities that we offer others will enhance the abilities that they have. Relationship in this sense is not going to be based upon what we say, but what we do.

Gesture is a central feature of a communicative setting for the ecology that we call understanding. If there is a breakdown in the background, when relationship fails, then the mutuality of time is lost, events lose their context and we become isolated. We literally fall out with each other, fall out of time and thereby, understanding. This is the process of becoming isolated. To repair performance, then we have to offer a structure in time. Structured time is precisely what music is in all its myriad of styles and possibilities for performance. For those losing cognition, or struggling to regain cognition, then the achievement of musical form is the basis of an enhanced cognitive ability. In coma patients, this is the regaining of levels of consciousness (Aldridge, 2000b). Within our varying cultures we have repertoires of performance suitable for promoting understanding, the challenge for us as practitioners is to expand the repertoires of treatment necessary to achieve competent performance for those suffering with neuro-degenerative diseases.

We know that non-verbal behaviours like hand gestures convey important information and are a rich source of unspoken knowledge (Breckinridge Church, 1999; Goldin-Meadow, 1997, 1999, 2000; Mayberry and
Jacques, 2000; Mayberry and Nicoladis, 2000). They are robust across cultures and are used by people of various ages. Not only do they reflect understanding, they also shape understanding. Like utterances, they are an attempt to regain cognition; they are used to inform the listener of the state of the expresser. We judge intentions by gestures. In children gestures signal that a particular notion is available in the repertoire of understanding but not necessarily accessible to speech. However, for the elderly, we can see that a concept is retained in the repertoire but no longer accessible to speech or conscious reflection. Gestures also allow expressions that do not easily fit into a categorical system but still reflect aspects of the performer’s state. This eases the cognitive burden and for the understanding of emotions allows the performer to achieve emotional expression without prematurely labelling that emotion, in giving the emotion a particular valence.

Setting and performance

How we perceive sounds as music or noise is dependent upon culture. Art productions are a ritualised form of performance, as are some clinical encounters. Yet, the everyday stuff of life is improvised. How we participate in these performances, and understand what is happening, is a matter of culture. Culture too is performed.

One of those influential cultural aspects will be the setting within which the performance takes place. Thus the setting of the home, the clinic, the day-centre, the hospice, will be important for the understanding of the performance.

The nature of this performance too will be dependent upon the engagement between the performers, and this is inevitably emotional and sensual (Smith, 2000). Emotional relationship is a way of understanding the world and this is absolutely central for the sufferers of neuro-degenerative disease. We have the massive problem of agitation in demented patients, and the confounding problem of depression throughout the broad spectrum of disorders. Music therapy, with the cultural aspects of emotion and sensuality related to music, has an important role to play in relieving the suffering of these patients.

Musical performance does not cause feelings but is the embodiment of feelings given form. That is why music therapy is important for demented patients in that it offers a form for interaction. Feelings regain their shape such that they can be initiated, formed and resolved. The ideas of emotions achieving closure is important that it emphasises performances that are bodily satisfying, if not intellectually satisfying. What cannot be articulated in speech can be expressed through music, primarily because the medium of musical
performance is that of organised perceptions and related actions. The basis of human intimacy is the coordination of understanding between self and other. For infant and mother, it begins as a mutual dialogue. Such dialogues also occur for adults and we simply have to extend our repertoires of caring such these can be achieved. Music therapy is one form of acceptable intimate dialogue.

If our bodies are the source of musical performance, then disruptions in kinesis, rhythm and hearing will disturb that performance. The goal of therapy will be to restore the organisational property that binds these sources of performance together, such that coherence of the whole person can be achieved once more. This binding, organizational property is time experienced as musical form.

Gestures also boost activation levels and are involved in the temporal structure of thinking (Alibali et al., 2001; Alibali et al., 2000). We see this in the simple beat movements when people listen to music. Even when people are talking on the telephone they gesture. The use of gesture also modulates responses to sensory input. Where agitation is a problem then gesture is an attempt to regulate arousal, either as an over sensitivity or as mentioned earlier to boost activity. Sensory integration, including proprioception, demands an adaptive response if communication is to take place. Integration requires arousal (maintaining alertness), attention (ability to remain focussed on a desired stimulus or task), affect (emotional regulation) and action (goal-directed behaviour as praxis in planning behaviour).

For patients in neurological rehabilitation, it is imperative that sensory integration is promoted as soon as possible and that this integration can be practiced, maintained and achieved through active musical play. For the active synchrony of neural events then a pattern of strong signals has to be established and this demands orientation with focussed attention with a conscious discrimination of auditory events Carrollphelan, 1996 #296] (Engel and Singer, 2001). Robertson et al. (Robertson et al., 1997) write that insufficient attention to tasks can result in slips of action as automatic, unintended action sequences are triggered inappropriately. Such slips arise in part from deficits in sustained attention, which are particularly likely to happen following frontal lobe and white matter damage in traumatic brain injury.

Mood regulation

“It is not the affect that regulates people rather than people regulating their affect” (p210) (Erber and Erber, 2000).

A central feature of our emotional lives is the ability to regulate our emotions (Larsen, 2000). Indeed, when such regulation fails, then we

take it as a sign that something is going wrong and in the extreme, we suspect a psychological disturbance. Affective states also influence attention, alter the way in which we perceive the world and influence our social relationships. Emotions are expressive, and we achieve this expression through gesture, postural changes, facial expression and the use of voice. It is not what we say, but the way that we say it that indicates our emotional state and intentions. The musical parameters of communication indicate emotional valence.

Emotions are bodily events that have shape and duration. How these events are regulated on a daily basis is also a matter of ecology balancing our personal environment and the social world. Although we consider our emotional

Life to be personal, it takes little persuasion to convince us that it is our lives with others that has and influence on those emotional reactions. When we fail to interact satisfactorily with others, then a source of emotional regulation may also fail. If we lose attention with both external and internal events then there is loss of feedback and the potential for emotional disregulation. We need to know, for example, the difference between a current state and a desired state. This is a cognitive activity. The linking of emotional events to understand the profile of an emotion is a matter of time. The ability to express emotions is important but also the facility to inhibit emotions forms the profile of our everyday lives. Choosing the form of an emotion, in terms of expression and inhibition, is necessary for appropriate emotional articulation. In dementia of the Alzheimer’s type, agitation is a problem of emotional expression. Agitation being a state of emotional arousal, that fails to achieve a satisfactory emotional form, that appears to have no potential for inhibition and thus no closure as an emotional form.

Motor mimicry is an essential feature of empathy and understanding the other person (Neumann and Strack, 2000). Facial and postural expression influence emotional expression. Thus the perceptions of another person’s behaviour may activate the same action codes within the observer that generate that behaviour. Thus, how we approach the demented is important in the way in which they will respond. Imitation is a feature of musical play and used in improvisation.

We also judge the expressive behaviour of others to know something about ourselves. The vocal expression of emotion embedded in the speaking voice is a powerful indicator of relationship and promotes a response. Expressed emotions promote congruent mood states in the listener; therefore we have to be as careful about how we say what we do as what we say. In music therapy, the use of timbre is central to emotion expression, as it is in the performance of operatic arias.
Cohen-Mansfield (Cohen-Mansfield, 2000) writes of the need to recognise the unmet needs of dementia patients where symptoms may be an attempt to alleviate need (pacing provides stimulation), agitation may be an over-expression of emotional arousal), that symptoms may be an attempt to communicate needs, and that behaviour may represent the outcome of an unmet need (crying from pain).

Children and adolescents who sustain brain injuries may also experience episodic agitation during the course of their recovery where agitation may be the direct effect of the neurological insult itself, as well as the child's response to physical pain and to his or her confusing surroundings. Later during the recovery process, agitation may occur in response to increasing demands made of the child and in response to feelings of loss. Agitation in children is a communication and attempts to provide the child with comfort, support, and alternative ways to communicate help. If health care staff and family members understand the underlying factors driving agitation, and recognize it as a transient phase of recovery, then the broader treatment strategy is enhanced (Deaton et al., 1995).

Nurses and music therapists have emphasized the benefits of music (Ragneskog and Kihlgren, 1997; Thomas et al., 1997) or music therapy (Brotons et al., 1997; Brotons and Pickett-Cooper, 1996; Vink, 2000) for the relief of agitation. Such interventions encouraging forms of expression will encourage unmet needs to be resolved.

**Time achieves form**

My hypothesis is that music offers the patient an alternative form for structuring time that fails in the working memory of the demented and is not yet made manifest in the coma patient. To achieve mentation, cognition, and consciousness then we must be brought into movement.

Initially this movement is achieved through the rhythm of breathing and then through gesture and bodily movements in a context of musical improvisation. The coordinated time structure for these movements is musical performance where the rhythmical intentions of the therapist combine with the basic rhythms of the patient. When tomes are connected together intentionally, then we have the phenomenon of melody. The extension of melody on the basis of rhythm in time is “memory”. Once memory is extended further in time, then we have the achievement of consciousness.

**Temporal coherence and memory**

Music therapy is indicated in neurological rehabilitation because it offers an external sense of temporal coherence that is latent in the patient through the dialogue of relationship.
We know that the nature of communication breakdown, how it is signalled, how it is repaired, and the outcome of the repair process appears to be disease stage-dependent. Couples in the early and middle stage of neurological disease achieve success in resolving communication breakdowns despite declining cognitive, linguistic, and conversation abilities of the individuals with the disease (Orange et al., 1998). This has important implications for understanding the influence of the progression of neuro-degenerative diseases on conversational performance and for advancing the development of communication enhancement education and training programmes for spousal caregivers of individuals with such diseases. Similarly, in coma, post-coma recovery and rehabilitation, we will expect to see, and hear, stages of recovery. Rehabilitation then will entail a recovery of that ecological niche which we call “communication”, this is achieved in the mutuality of performance as dialogue. For sufferers, we are that recovery, we are the context offering them an ecological niche. That is, we are communication and our responsibility lies in developing our own communicative abilities beyond the use of words. As living beings we perform in relationship with our milieu, a milieu that includes others. This ecological milieu is established through a dynamic mutual interaction. We establish communicative forms, these are inherently of time and musical. In this sense, memory is not the recovery of facts but the performance of reality linking events. What we experience as development is a creative act of improvising forms for being in time, this we experience physically as the body but psychologically as consciousness.

Benefits of music therapy

As Cohen-Mansfield (Cohen-Mansfield, 2000) suggests, therapeutic interventions need to be tailored to meet the needs of individual patients and their characteristics. In various social and treatment settings, music therapy can promote dialogue. The implication of such dialogues is that the sufferer can maintain, or even recover, an identity that has a broad repertoire of possibilities. When we enter into such dialogues, then the caregivers are also offered a broader potential of identities. The sufferer is reintegrated within a communicative ecology and this prevents isolation.

Music therapy offers a flexible temporal structure for processing temporal information. If timing is an ability that is failing, then musical form offers an alternative form within which timing can be temporarily recovered and practiced. The expression of timing in communication will utilise gestural abilities, including utterance, that spontaneous bind events together and are indicative of performed ability. Gestures are seen within this context as attempts to regain
cognition, not solely as failed abilities.

As emotional regulation is a common core problem within these diseases, attempts to positively regulate emotion will have benefits for both sufferers and carers. Emotional arousal is located within a context of attention and action whereas needs may be unmet, are unable to be expressed or are fail to be recognised. The expression of emotion, and similarly the ability to inhibit arousal, will contribute to communicating needs effectively.

Communicative abilities are essential. This mutual need is usually achieved through speech. When speech fails, then it is important to utilise those properties of human communication that are not speech dependent. Attention, arousal, affect and action all occur in musical performance. Music therapy has the potential to promote communication, stimulate cognitive abilities and alert us to residual communicative abilities.

Gesture and dialogue then are important activities for communication. Indeed this embodied activity is communication. To enter into dialogue with the other, then we must ourselves embody those rhythms of common rhythms of consciousness, and this is achieved through music therapy. By playing together, we achieve that understanding necessary for dialogue and thus an embodied hermeneutic.

**Table 1 Benefits of music therapy for the neuro-degenerative diseases**

<table>
<thead>
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<th>Benefit</th>
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<tr>
<td>Meets the needs of individual patients and their characteristics</td>
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<tr>
<td>Promotes dialogue and the maintenance of an identity that has a broad repertoire of possibilities</td>
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<tr>
<td>Reintegrates the person within a communicative ecology and prevents isolation</td>
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<tr>
<td>Offers a flexible temporal structure for processing temporal information where timing can be temporarily recovered and practiced</td>
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<tr>
<td>Utilises gestural abilities, including utterance, binding events together that are indicative of ability</td>
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<td>Gestures are seen as attempts to regain cognition, not seen as failed abilities</td>
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<tr>
<td>Regulates emotional arousal in terms of expression and inhibition with implications for sufferers and caregivers</td>
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<tr>
<td>Need can be expressed</td>
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<tr>
<td>Motivates communication and participation without being speech dependent</td>
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<td>Attention, arousal, affect and action embodied in musical form</td>
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The creative arts therapies in the treatment of neuro-degenerative illness

David Aldridge

Neuro-degenerative diseases are, and will remain, an enormous public health problem. Interventions that could delay disease onset even modestly will have a major public health impact. These diseases are disabling to the sufferers, there is a loss of normal motor functioning, a change in mood, and a gradual loss of cognitive abilities. Furthermore, we do not suffer alone, these losses have an impact upon family and social life. While there are numerous projects aimed at finding medical relief for suffering and the treatment of disease, we are reminded that these problems are also illnesses. Behaviour is influenced. We are challenged as a society that people within our midst are suffering and it is our responsibility within the delivery of health care to meet that challenge with appropriate responses. A major confrontation for those offering treatment, as it is for the patient, is that the problem itself is degenerative; there is no cure. Furthermore, the problems facing patients confront the deepest fears of a consumer success oriented society. Decline, physical and mental, is not readily faced within communities that expect youth appearance, worldly success and physical ability as the outer sign of acceptable personhood (Aldridge 2000b).

In 1997, the numbers of individuals in the United States with Alzheimer’s disease was estimated 2.32 million (range: 1.09 to 4.58 million); of these individuals, 68% were female. The numbers of newly diagnosed cases that can be expected over the next 50 years were estimated from a model that used age-specific incidence rates summarised from several epidemiological studies and is projected that the prevalence will nearly quadruple in the next 50 years, by which time approximately 1 in 45 Americans will be afflicted with the disease (Brookmeyer, Gray, and Kawas 1998).
The prevalence of dementia in subjects 65 years and older in North America is approximately 6%-10%, with Alzheimer's disease (AD) accounting for two-thirds of these cases (Hendrie 1998). If milder cases are included, the prevalence rates double. While a genetic basis for Alzheimer's disease has been identified, the search for non-genetic risk factors has been less conclusive. Only age and family history of dementia are consistently associated with AD in all studies. Dementia is an important source of chronic disability leading to both spiralling health care expenditure among the elderly and a progressive disturbance of life quality for the patient and his or her family. In the United States of America the cost of institutional care for patients with dementia is estimated at over $25 billion a year. If 4% to 5% of the North American elderly population suffer from dementia then 1.25% of the total population are suffering with the problems of severe dementia. Other estimates of the same population suggest that 15% of those over the age of 65 will have moderate to severe dementia with projections to 45% by the age of 90 years (Aldridge and Aldridge 1992; Aldridge and Brandt 1991). As the prevalence of dementia increases dramatically with age, the elderly represent the largest population manifesting dementia (Brotons, Koger, and Pickett-Cooper 1997). With anticipated increases in the population of the elderly in Europe *, then it is timely to find treatment initiatives in the Western world which will ameliorate the impact of this problem.

It is in a primary care setting where dementia is recognised, and early recognition is important for initiating treatment interventions before a person becomes permanently or semi-permanently institutionalised and to minimise disability (Larson 1998). The challenge that we face is how to handle such a progressive degenerating disability over time.

Parkinson's disease is also a common neuro-degenerative disease affecting approximately 1% of the elderly population. The disease is defined by motor abnormalities, the signs of which are bradykinesia, rigidity and tremor when the body is at rest. The clinical picture is, however, much more complex, and patients with Parkinson's disease, like those with Alzheimer's disease are prone to affective disturbances, anxiety syndromes and possibly psychosis (Marsh 2000b).

Multiple Sclerosis is a progressive disease resulting in motor disturbances, sensory disturbances and changes in cognition. Although treatments are continually being

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* between 23% and 25% of the national populations aged over 65 by the year 2040

sought, those available orientate themselves to the relief of symptoms and palliation. As in the other disease we see a picture of cognitive dysfunction and sometimes dementia (Mahler and Benson 1990). When combined with the severest possible symptoms of ataxia or paralysis impairing nearly all voluntary and functional movement, loss of speech, the inability to swallow, and extreme fatigue, the individual can experience self doubt, anxiety, and reduced self esteem (Randall 1982).

Huntington's Disease is also a chronic progressive hereditary disease affecting the central nervous system. Here too we see large involuntary movements and abnormality of those movements accompanied by gradual cognitive deterioration. Emotional disorders, behavioural problems and personality changes may be experienced, leading to psychiatric symptoms as we have seen in the other degenerative diseases (Folstein, Folstein, and McHugh 1975; Morris 1991). Speech is increasingly challenged as the disease progresses. In terms of communication and movement, then

initiation, spontaneity and rate of speech are influenced. However, insight may remain into the most advanced stages of the illness (Shoulson 1990) The average age of onset is 36 - 45 years of age, and, like the other degenerative disease appears to follow stages (Folstein 1989). Studies examining the duration of the illness have yielded widely varying results, suggesting between ten to forty years duration after onset (Harper 1991).

In all the above disease we see a common core of progressive deterioration; a loss of bodily integrity, failing cognitive competence and the demise of emotional coherence. To this we must add the potential for social isolation that this deterioration brings, and isolation is the road to despair (Aldridge 1998) (see Figure 1). Any adjuvant therapies that will address these factors will offer a significant part of a modern treatment strategy for the neuro-degenerative disease. The expressive arts therapies are to be considered as a part of this strategy.
Clinical descriptions of dementia

The clinical syndrome of dementia is characterised by an acquired decline of cognitive function which is represented by memory and language impairment. While the term dementia itself is used widely throughout the medical literature, and in common usage, to describe cognitive impairment it is generally applied to two conditions: dementia of the Alzheimer’s type (DAT) and multi-infarct dementia.

The course of Alzheimer’s disease is one of progressive deterioration associated with degenerative changes in the brain. Such deterioration is presented in a clinical picture of episodic changes and a pattern of particular cognitive failings which are variable (Drachman, O’Donnell, Lew et al. 1990). Mental status testing is one of the primary forms of assessing these cognitive failings which include short and long term memory changes, impairment of abstract thinking and judgement; disorders of language (aphasia), and difficulty in finding the names of words (anomia); the loss of ability to interpret what is heard, said and felt (agnosia); and an inability to carry out motor activities, such as
manipulating a pen or toothbrush, despite intact motor function (apraxia). When such clinical findings are present then a probable diagnosis can be made, a more definite diagnosis depends upon tissue diagnosis. Aldridge has suggested that music therapy provides a sensitive ecological method of assessment for determining cognitive abilities that are residual when speech is being lost and communicative abilities within an ecological context that makes sense to the patient (Aldridge 1993a; Aldridge and Aldridge 1992; Aldridge 1994; Aldridge and Brandt 1991; Aldridge 1993b). Indeed, the music therapy setting can be experienced as less challenging than cognitive testing, and therefore unconfounded by patient anxiety.

While dementia of the Alzheimer’s type begins after the age of 40, and is considered to be a disease of the elderly, the influence of age on prognosis is not as significant as the initial degree of severity of the problem when recognised (Drachman et al. 1990). Disease severity, as assessed by intellectual function, appears to be the most consistent predictor of the subsequent course of the disease particularly when accompanied by a combination of wandering and falling, and behavioural problems (Walsh, Welch, and Larson 1990). However, the rates of decline between sub groups of patients are variable and a patient’s rate of progression in 1 year may bear little relationship to future rate of decline (Salmon, Thal, Butters et al. 1990). Some authors (Cooper, Mungas, and Weiler 1990) suggest that an as yet unproven factor, other than declining cognitive ability, may also play a part in the associated abnormal behaviours of anger, agitation, personality change, wandering, insomnia and depression which occur in later stages of the disease.

A performed identity

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 per-form-ances. Thus we need an authored identity to express the distress in a coherent way with
others to generate intelligible accounts (Aldridge 2000b). 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 2000).

The patient and his or her family have a story about the problems they face. And this story has to be told. It is in the telling that we understand what needs are. It is also in the 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.

The nature of communication breakdown, how it is signalled, how it is repaired, and the outcome of the repair process, appears to be dependent upon the stage of the disease. What is unknown, however, is the nature of the longitudinal changes in the resolution of communication breakdown over the progression of the disease. In the early and middle stages of a progressive disability, then it is possible to achieve some success in resolving communication
breakdowns despite declining cognitive, linguistic, and conversational abilities of the sufferer. We may need to consider not just the patient but the caregivers too in training programmes (Orange, VanGennep, Miller et al. 1998).

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. In a series of studies by Pennebaker (Dienstfrey 1999; Pennebaker, Kiecolt-Glaser, and Glaser 1988), writing as disclosure of distressing experiences is seen to have health care benefits. 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. We will see later that when a piece of favourite music is played then there is a cascade of memories from an initial prompting, even if we can’t remember the name of the composer or lyricist. As individuals we are stories, we are composed and those compositions remain.

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. Thus we would expect to see people not only having sets of beliefs about health but also actions related to those beliefs. Some of these may be dietary, some involve exercise, some prayer or meditation, some medication and others artistic.

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. 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.

If we take my earlier metaphor of composition, when bodily function fails, then we are literally decomposed. 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 who come to us for help.

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 is that this identity is performed. Both personal and social are necessary. The interaction of personal and social is circular, and the difference between them constructed. 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 in earlier books the concept of human being as being like a piece of improvised music (Aldridge 1999; Aldridge 2000b). 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. Exactly so with 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 1990, Aldridge 1996). 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.

The body has perhaps been neglected in communication studies as we emphasise language, yet it is gesture that is pre-verbal and promotes thought. 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 is the bodily form that guides communication and by which the other may be understood and has an ambiguous content, it is social. Language provides a specific content, it is cultural. We know that someone is suffering by their 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.

Understanding each other

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.

Creative arts approaches and the promotion of identity

The maintenance of an intact identity is central therapeutic principle in working with those suffering from neuro-degenerative diseases (Aldridge 2000a; Harlan 1993) (Johnson, Lahey, and Shore 1992) (Magee 1999). At the same time, we also see that coping with emotions and finding a suitable form for the expression is necessary and is facilitated by the expressive arts therapies. Furthermore, we also find that the arts therapies motivate suffers to communicate and this itself is a way out of what is often an increasing isolation. Expressive arts offer a challenging and stimulating experience within the capabilities of the sufferer (Harlan 1993).

Magee alerts us to working with individuals who have advanced neurological disabilities (Magee 1998). She writes that one of the many challenges for the therapist is that of finding instruments which are appropriate to meet a diverse range of needs. Instruments, particularly those that are safe for the uncontrolled nature of ataxic or choreic movements and sensitive to the very small, weak or fatigued movements (Magee 1999). In a process of “illness monitoring”, through the involvement in music therapy, patients are aware of cognitive, vocal and physical changes (Magee 1998). Through playing instruments within clinical improvisations, individuals monitored their physical abilities to manipulate instruments and control the sounds they produced. Aldridge (Aldridge and Aldridge 1992) also found a similar situation when playing with a female patient who became aware of her failing capabilities as well as the benefits of music playing.

It is, however, the maintenance of ability and in some case even the promotion of potentials that is a valuable therapeutic resource for such patients despite a prevailing sense of loss. Music therapy challenges a stigmatised and changed identity (Aldridge 2000a). Through actively playing, people have the opportunity to experience themselves as both creative and beautiful in the midst of deterioration and a severely curtailed future.
Research approaches to new treatments

Brotons (Brotons 2000; Brotons et al. 1997; Brotons and Pickettcooper 1996), and her colleagues (Koger, Chapin, and Brotons 1999), has reviewed the literature relating to the music therapy treatment of dementia. Research outcomes were categorized, coded, and summarized to outline recommendations that may be used in clinical practice as well as in future research. In general, music/music therapy is an effective intervention to maintain and improve active involvement, social, emotional and cognitive skills, and to decrease behavior problems of individuals with dementias. What is lacking is an effective clinical trial of music therapy. Vink (Vink 2000), in Holland, is about to implement a controlled clinical study of music therapy for the relief of agitation in patients suffering with dementia. Music therapy is seen as a potentially important non-pharmacological approach in the management of agitation.

Until recently, psychotherapy and counselling techniques had rarely been used with people with dementia. However, the change in emphasis within dementia care towards a person-centred approach, and often non-pharmacological approach, has meant that there is a growing clinical interest in their use (Beck 1998; Bender and Cheston 1997; Bonder 1994; Cheston 1998; Johnson et al. 1992; Richarz 1997). This has also meant an increase in studies using creative arts therapies (Bonder 1994; Harlan 1993; Johnson et al. 1992; Kamar 1997; Mango 1992) and overviews of music therapy as a treatment approach to Alzheimer’s disease have already been written (Aldridge and Brandt 1991; Brotons 2000; Brotons et al. 1997; Smeijsters 1997).

Individuals with Alzheimer disease often experience depression, anger, and other psychological symptoms. Various forms of psychotherapy have been attempted with these individuals, including insight oriented therapy and less verbal therapies such as music therapy and art therapy. Although there are few data-based outcome studies that support the effectiveness of these interventions, case studies and descriptive information suggest that they can be helpful in alleviating negative emotions and minimising problematic behaviours (Bonder 1994).

Although there is a developing clinical literature on intervention techniques drawn from all the main psychotherapeutic approaches, there has been little research into the effectiveness of this work and such research as does exist often uses methodologies that are inappropriate for such an early stage of clinical development. While some authors (Cheston 1998) argue that clinical research should adopt case study or single-case designs, some researchers are also planning group designs for evaluating new clinical developments. My argument is for a broad spectrum of research designs that will satisfy differing needs but for music therapy to be accepted within a framework of health care delivery.
then we will need to commit ourselves to a series of clinical trials.

**The patient and his caregivers**

The absence of definitive treatments for Alzheimer’s disease and related dementias, researchers in a variety of disciplines are developing psychosocial and behavioural intervention strategies to help patients and caregivers better manage and cope with the troublesome symptoms common in these conditions. These strategies include cognitive interventions, functional performance interventions, environmental interventions, integration of self interventions, and pleasure-inducing interventions. Although more research is needed to further develop these strategies and establish their best use, psychosocial and behavioural interventions hold great promise for improving the quality of life and well-being of dementia patients and their family caregivers (Beck 1998; Orange et al. 1998).

We know that people who are suffering do not suffer alone (Aldridge 1998; Aldridge 1999). There is an increasing expectation that the community will care for its elderly infirm, although this expectation is rarely met by financial resources that will support such care-giving placing the caregivers under stress, while relieving a community budget in the short term.

Recent research on care-giver stress focuses extensively on its predictors and health consequences, especially for family members of persons with dementia, Gwyther and Strulowitz (Gwyther and Strulowitz 1998) suggest four areas of care-giver stress research: caregiver health outcomes, differential impacts of social support, care giving for family members with dementia, and balancing work and care-giving responsibilities.

In a study by Harris (Harris 1998), in-depth interviews with 30 sons actively involved in caring for a parent with dementia elicit the understanding of sons' caregiving experiences. Common themes that emerge from their narratives are a sense of duty, acceptance of the situation and having to take charge as well as issues regarding loss, a change in relationships with other brothers and sisters, the reversal of role from based on having to take charge and the necessity to develop coping strategies.

The psychological well-being of caregivers of demented elderly people was investigated (Pot, Deeg, and VanDyck 1997). Three groups of caregivers were distinguished: those providing care for two years after baseline; those whose care-recipient died within the first year after baseline, and those whose care-recipient was institutionalised within the first year. All groups of caregivers showed a great amount of psychological distress compared to a general population sample, with an overall deterioration of psychological well-being. As the elderly patient declined, and the caregiving at home continued, then psychological distress increased. For caregivers whose demented care-recipient had died or was institutionalised in the first year after baseline then there
was no deterioration. There is, then, a high level of psychological distress and deterioration in psychological well-being among informal caregivers of dementia patients and we may have to reconsider the personal and social costs of demented older people live on their own as long as possible if we are not able to release adequate resources to support the caregivers.

Part of this support will include sharing information and developing methods of counselling appropriate to caregivers. Increasing public awareness, coupled with the wider availability of drug therapies for some dementing conditions, means that carers are often informed of the diagnosis of dementia. However it is unclear how much sufferers themselves are told about their diagnoses. In a study of how sufferers of dementia were given diagnostic information of 71 carers recruited through old age psychiatry services in East Anglia, half of the sufferers had learned their diagnosis, more from their carers than their doctors (Heal and Husband 1998). The age of the sufferer was found to be related to whether or not doctors told them their diagnosis, which supports a suspicion that there is a prejudice regarding the elderly about what they can understand. Only 21% of carers were given an opportunity to discuss the issues involved and younger carers were significantly more likely to feel that such an opportunity would have been useful. Most of the carers who had informed the sufferer said that the sufferer had wanted to know, or needed a meaningful explanation for their difficulties, rather than giving more practical legal or financial reasons. Carers who had not disclosed feared that diagnostic information would cause too much distress, or that the sufferers’ cognitive impairments were too great an obstacle. The process of “informing” is a political act and demands the sharing of knowledge. While this is indeed a specialist medical task, the consequences of that task are explicated in a social nexus. Caregivers need to be informed that they can inform.

In the broadest sense of the term, knowledge as diagnosis is based not solely upon physiology but upon the deep needs of the patient and carers. Neither knowledge excludes the other, both can be reconciled. From such mutual knowledge, a prognosis can be made. The diagnosis of a medical complaint is also a statement about personal identity and the stigma that may be attached to such an identity. Understandings are the loci of power whereby illness is explained and controlled. In the demand for caregiver information, such loci are shifting from the educated health professionals to increasingly better-educated caregivers as consumers.

**Distress and the neuro-degenerative diseases**

Clearly neuro-degenerative diseases cause distress for the patient. The loss of memory and the accompanying loss of language, before the onset of motor impairment, means that the daily lives of patients are disturbed. Communication, the fabric of social contact, is interrupted and disordered. The threat of progressive
deterioration and behavioural disturbance has ramifications not only for the patient themselves, but also their families who must take some of the social responsibility for care of the patient, and the emotional burden of seeing a loved one becoming confused and isolated. Furthermore, we see a massive impact on the way in which the patient views his, or her future, as radically curtailed, confounded by an identity that is severely impaired.

In patients suffering with Parkinson’s disease, it is often the patient’s perception of the handicap that influences their emotional state than the actual disability itself (Schrag,iahanshahi, and Quinn 2001). While motor problems are an important feature of these diseases, from a patient’s perspective it is “difficulties in communication and maintaining independence; feelings of anxiety, foreboding, and depression; lowered self-esteem; limitations in social interaction, and the loss of accustomed activities” that are just as debilitating (Brod, Mendelsohn, and Roberts 1998). Indeed, it is mastery of these varying problems that is considered to be important in improving the quality of life of sufferers (Koplas, Gans, Wisely et al. 1999).

Emotional context and ability

As we saw in the above example, it is important to consider the internal world of the sufferer. Bender and Cheston (Bender and Cheston 1997) present a stage model of the subjective world of dementia sufferers drawing on ideas from both clinical and social psychology. The first stage involves feelings engendered by the process of dementia and includes four discrete states of anxiety, depression, grief; and despair. The second stage of the model concerns the behaviours provoked by process of decline. Finally, a continuum of emotions is considered, where the ability of an individual with dementia to engage in emotional behaviour depends upon the extent of their cognitive impairment and the social context in which they are located. In another study (Vasterling, Seltzer, Carpenter et al. 1997) examines unawareness of social interaction and emotional control competency. Impaired awareness of social interaction and emotional control deficits is positively correlated with dementia severity.

As the disease progresses there is a degeneration of the ability to comprehend and express emotion that is linked with mental impairment (Benke, Bosch, and Andree 1998). The creative arts therapies have based some of their interventions on the possibility for promoting emotional expression and retaining expressive abilities.

Emotional changes

A source of error in diagnosing Alzheimer’s disease is that it is masked by other conditions. Principle among these conditions is that of depression which itself can cause cognitive and behavioural disorders. In addition it is estimated that 20% to 30% of patients with Alzheimer’s disease will have an accompanying depression (Kalayam and Shamoian 1990) thereby compounding diagnostic problems further.
We see the same picture emerging in other neuro-degenerative diseases.

At the very onset of Parkinson's disease, a group of patients were so demoralized by the disease that they refused treatment, and an association between depression and Parkinson's disease is still considered to be a part of the clinical picture. Apart from this emphasis on depression, we also see an emerging picture of anxiety syndromes being recognized in the neuro-degenerative disease (Kremer and Starkstein 2000). Marsh emphasises that while the focus has been on depressive symptoms and syndromes in Parkinson's disease, anxiety syndromes are increasingly being recognized as a common problem (Marsh 2000a).

Similarly, in multiple sclerosis, major depression is considered to be an important clinical problem that diminishes quality of life and when untreated, worsens (Mohr and Goodkin 1999). The prevalence of depression in multiple sclerosis is estimated to be between 36 percent to 50 percent in sufferers (Wang, Reimer, Metz et al. 2000). In Sullivan et. al's study, fifty two percent of multiple sclerosis patients reported a depressive episode before the onset of the disease compared to 17% of patients suffering with low back pain (Sullivan, Weinshenker, Mikail et al. 1995).

In all these disease profiles mentioned so far, we can see that an affective disorder is significant in the way that patients lives are influenced and may also have an influence on the way that treatment is effectively delivered. Music therapy, with its known anxiolytic effect and its potential for influencing mood, offers a potential for direct therapeutic intervention and as an adjuvant therapy.

**Depression**

Depression is a common disorder in the elderly (Forsell, Jorm, and Winblad 1998). The rate of treatment of depression in the very elderly is low, exaggerated amongst dementia sufferers, and the course is chronic or relapsing in almost half of the cases. The interface between depression and dementia is complex and has been studied primarily in Alzheimer's disease (Aldridge 1993a) where depressive depression may be a risk factor for the expression of Alzheimer's disease in later life (Raskind 1998). A contributory factor to this depression is the patients' perceptions of their own deficits, although these may be ill-founded (Tierney, Szalai, Snow et al. 1996). Emotional context is an important factor and this will be linked to the way in which the patient sees his or her current life situation and an understanding of what life holds in the near-future.

Hope will be a major coping strategy for achieving the best out of a situation. Depression will work against this. Conversely, hope combats depression. Life aims can be redefined and refocused. With the progression of physical deterioration then the future becomes less defined in terms of the body and time, but in the meaning attached to life events in relationship with family and friends. Hope is a replacement for
therapeutic nihilism enabling us to offer constructive effort and sound expectations.

Hearing impairment

If depression is a confounding factor in recognising cognitive degeneration, then hearing impairment is another contributory factor. Central auditory test abnormalities may predict the onset of clinical dementia or cognitive decline. Hearing loss significantly lowered performance on the verbal parts of the Mini-Mental State Examination, a standard test for the presence of dementia (Gates, Cobb, Linn et al. 1996). Central auditory dysfunction precedes senile dementia in a significant number of cases and may be an early marker for senile dementia. Gates et al. recommend that hearing tests should be included in the evaluation of persons older than 60 years and in those suspected of having cognitive dysfunction. If this is so then we may have to include this consideration in designs of research studies of music therapy as maybe the patients themselves are not actually hearing what is being played but responding to social contact and gesture.

Gesture

Gesture is a part of language. When spontaneous communicative hand-arm gestures are evaluated in elderly patients with probable Alzheimer's disease and compared to those of healthy controls, patients with Alzheimer's disease produced proportionately more referentially ambiguous gestures, fewer gestures referring to metaphoric as opposed to concrete contents, and fewer conceptually complex bimanual gestures. Impaired clarity while gesturing correlated with severity of linguistic impairment and disturbed production of pantomimic movements on a test of ideomotor limb apraxia. (Glosser, Wiley, and Barnoski 1998). This ties into work that we found with developmentally-challenged children. When children developed a better hand-eye coordination, and improved gesturing, then they began to score on cognitive subscale of the Griffith's test of child development. Gesturing is an important part of meta-communication, and it is gesturing that can be fostered by the expressive and creative arts when verbal language fails (Aldridge 1996).

In our study of developmentally-challenged children, where hearing disability was ever present, it was the joint attention involved in making music that brought about an improvement in listening that appeared as an improvement in hearing. This listening feature of active music therapy is something that needs to be further investigated in its connection with gesture. The combination of the focused awareness necessary for listening, and the companion visual modality of gesture, aid coherent expressive communication. Indeed, it is task orientated therapies that focus perception and action, thus enabling competence and are a step to regaining some integrity.

What happens

Most music therapists have concentrated on the pragmatic effects of music therapy. As we will
see, both practitioners and researchers alike are concerned with demonstrating the benefits of music therapy for dementia sufferers. However, how music therapy actually achieves its effects is relatively un-researched although Thaut and his colleagues have made significant investigations into the role of rhythm in gait analysis (Thaut and McIntosh 1999; Thaut, McIntosh, Rice et al. 1996; Thaut, Miltner, Lange et al. 1999) and Pacchetti et al (Pacchetti, Mancini, Aglieri et al. 2000) have made a study of active music therapy in Parkinson's disease as an integrative method for motor and emotional rehabilitation bringing about an improvement in quality of life. Grün (Grün, Dill-Schmölders, and Greulich 1999) and his colleagues too have studied the impact of music therapy for the rehabilitation of patients with Parkinson's disease.

Rhythm constitutes one of the most essential structural and organizational elements of music. When considering the effect of music on human adaptation, the profound effect of rhythm on the motor system strongly suggests that the time structure of music is the essential element relating music specifically to motor behavior (Aldridge 1996). It is the coupling of rhythm and motor action that is central to active music making and this is the feature of several therapeutic interventions. Grün et al (Grün et al. 1999) found that patients with Parkinson's disease had difficulty in maintaining a stable musical tempo; a reduced ability in freely forming rhythms; and that in improvised playing there was a monotony of speech tone and emotional flatness reflecting the inflexibility of rhythmic form. Pacchetti hypothesizes that it is external rhythmic cues that stabilize the internal formation of rhythm in the patient (Pacchetti et al. 2000).

Structured time

My hypothesis is that music offers an alternative form for structuring time that fails in working memory. Just as developmentally delayed children achieve a working memory that enhances their cognitive ability, then the reverse process occurs in dementia sufferers. The inability to maintain, and freely form, rhythm is an expression of this deficit.

An 82 year old musician with Alzheimer's disease showed a preserved ability to play previously learned piano compositions from memory while being unable to identify the composer or titles of each work. He also showed a preserved ability to learn the new skill of mirror reading while being unable to recall or recognise new information. Both anterograde and retrograde procedural memory appeared to be spared in Alzheimer's disease (Crystal, Grober, and Masur 1989).

While several components of working memory may be affected not all aspects of the central executive mechanism are necessarily influenced (Collette, VanderLinden, Bechet et al. 1998). White and Murphy (White and Murphy 1998) suggest that tone perception remains intact, but there is a progressive decline in working memory for auditory nonverbal information with
advancing Alzheimer's disease. A similar decline was also noted on a task assessing working memory for auditory presented verbal information. This ties in with what we know about hearing impairment and again encourages a test of hearing capabilities before music therapy is used as a treatment modality.

**Temporal coherence**

In an earlier article, I argue that music therapy is indicated because it offers an external sense of temporal coherence that is failing in the patient. Ellis (Ellis 1996) reports on the linguistic features and patterns of coherence in the discourse of mild and advanced Alzheimer's patients. As the disease progresses, the discourse of Alzheimer's patients becomes pre-grammatical in that it is vocabulary driven and reliant on meaning-based features of discourse rather than grammatically based features. Temporal coherence fails. Knott, Patterson, and Hodges (Knott, Patterson, and Hodges 1997), considering the short-term memory performance of patients with semantic dementia, suggesting that impaired semantic processing reduces the "glue" or "binding" that helps to maintain a structured sequence of phonemes in short-term memory. I argue that this temporal coherence, the metaphoric glue or binding, is replaced by musical form.

**Not loss of semantic memory**

Several lines of evidence suggest that in Alzheimer's disease there is a progressive degradation of the hierarchical organization of semantic memory. The structure of semantic memory in Alzheimer's disease is probably degraded but there is no evidence that this process is progressive. Instead, progressive worsening of verbal fluency in Alzheimer's disease seems to be associated with the deterioration of mechanisms that govern initiation of search for appropriate subcategories (Beatty, Testa, English et al. 1997). This pattern can be interpreted as reflecting significantly impaired procedural routines in Alzheimer's disease, with relative sparing of the structure of semantic memory (Chenery 1996).

**No loss of source memory**

A source memory task, using everyday objects in actions performed by either the participant or the experimenter, was given to probable Alzheimer's disease and elderly normal individuals (Brustrom and Ober 1996). When the overall recognition performance of the two groups was made equivalent by increasing the test delay intervals for the control group, both groups of participants showed similar patterns of correct and incorrect responses. For a given level of event memory, memory for the source of the events is comparable between elderly normal and individuals with Alzheimer's disease.

**Contextual cues**

Two experiments examined whether impairments in recognition memory in early stage Alzheimer's disease were due to deficits in encoding contextual information. Normal elderly and patients diagnosed with
mild stage Alzheimer’s disease learned one of two tasks. In an initial experiment, correct recognition memory required participants to remember not only what items they had experienced on a given trial but also when they had experienced them. A second experiment required that participants remembered only what they had seen, not when they had seen it. Large recognition memory differences were found between the Alzheimer’s disease and the normal elderly groups in the experiment where time tagging was crucial for successful performance. In the second experiment where the only requisite for successful recognition was remembering what one had experienced; memory of the temporal record was not necessary for successful performance. In this instance, recognition memory for the both groups was identical. Memory deficits found in early stage Alzheimer’s disease may be partly due to impaired processing of contextual cues that provide crucial information about when events occur (Rickert, Duke, Putzke et al. 1998).

Foster (1998) carried out a series of studies of background auditory conditions that provided such a context, and their influence upon autobiographical memory. While the use of background music has no effect on word-list recall in the normal elderly, there is a constant beneficial effect of music for autobiographical memory for patients with Alzheimer’s disease. This music did not have to be familiar to the sufferer, nor did it reduce anxiety. The effect of music is stronger in cognitively impaired participants thus promoting another reason for using music-based interventions in treatment initiatives. Foster, like Aldridge (Aldridge 1993a), argues for the use of music in assessment procedures.

As part of a programme of studies investigating memory for everyday tasks, Rusted et al (1997) examined the potential of auditory and olfactory sensory cues to improve free recall of an action event (cooking an omelette) by individuals with dementia of the Alzheimer’s type. Both healthy elderly and volunteers with Alzheimer’s disease recalled more of the individual actions which comprised the event when they listened, prior to recall, to a tape of sounds associated with the event. Olfactory cues which accompanied auditory cues did not produce additional benefits over auditory cues alone. The pattern of recall suggests that the auditory cues improved recall of the whole event, and were not merely increasing recall of the specific actions associated with the sound cues. Individuals with Alzheimer’s disease continue to encode experiences using a combination of senses, and that they can subsequently use this sensory information to aid memory. These findings have practical implications for accessing residual memory for a wide range of therapeutic activities using the creative arts that emphasise sensory abilities.

**Reminiscence**

Persons with Alzheimer’s disease experience progressive memory and language losses. When people suffering with Alzheimer’s disease
tell their own stories, then those narratives are less chronologically organized, include repetitions, often omit salient events, and contain less detail in description than participants in comparison group. In addition, most members of the Alzheimer's disease group sought assistance during the narrative task. Nevertheless, these persons were willing and able to complete their narrative assignment despite limitations (Usita, Hyman, and Herman 1998) mirroring a situation in music therapy (Aldridge 1999).

In Mills' study (Mills 1997) of eight demented elderly people in a psychogeriatric day service setting, emotions associated with past experiences provided a strong cue to recall and formed a significant feature of their accounts as well as providing all informants with narrative identity. This sense of narrative identity began to dissolve as their illness progressed and stories faded from memory. The active participation in story-telling may be a crucial feature of maintaining a social identity and is available to several forms of therapeutic activity involving the expressive arts therapies.

Silber (Silber and Hes 1995) investigated the value of song/poetry writing with patients diagnosed with Alzheimer's disease. A music therapist facilitated the writing exercise by proposing the themes, choosing music, writing the patients' dictated text, suggesting the use of metaphors and/or analogies, and deciding when the concluding sentence had to be written. Patients wrote songs based on descriptions and images of seasons and the themes of love and stages of life. Results suggest that, based on the preservation of memory for tunes and melodies, patients were able to write songs and poetry when assisted by appropriate stimuli and provided encouragement. The activity of songwriting not only provides pleasure to the participants but also improves group cohesion and social interaction.

Magee has used songwriting extensively in her music therapy practice (Magee 1998; Magee 1999), as has Clare O'Callaghan (O'Callaghan 1999). Traditionally music offers a valid form of emotional expression, and using songs allows people to find an appropriate social form for the expression of strong emotions. Furthermore, some emotions need to be expressed before they achieve recognition for what they are. It is in the act of expressing that we understand ourselves and are similarly understood by others. The expressive arts then will play a vital role in stimulating emotional expression and achieving emotional expression. If this is so, then we can see the important treatment for those condition where depression plays a role in the course of the disease, and particularly where depression is seen as a confounding factor that worsens the clinical picture.

Taking this argument further, we may need to investigate the possibilities that music therapy offers an appropriate form for emotional expression. This means that patients suffering from intense labile emotions, or the severe agitation of
later stage dementias, can be offered a non-pharmacological therapy by which emotions can be regulated.

Coda

The creative arts therapies offer a broad potential for addressing the problems encountered by patients suffering with neuro-degenerative diseases.

Facilitating communication

Gesture is a part of language and promotes thought. Posture, movement and prosodics provide the bases for communication. The moved body is important for expressing and articulating emotion. The creative arts therapies involving music and dance are grounded in movement.

Retaining identity and promoting memory

For those struggling with to articulate themselves, the structuring of narratives offers a meaningful context in which expression can occur. Remembering a story offers an overarching framework that links events together. When a piece of favourite music is played then memories are evoked.

Encouraging rhythmic movement

When bodily integrity begins to fail, then sufferers literally fall out of time. If this is, as speculated, because an internal timekeeper fails to function, then an external source of time appears to resynchronise movements. What we do not know is how long the benefits of such rhythmic facilitation lasts. Certainly music and dance promote fluency in movement and speech. What we do know is that tasks are central to the whole process of perception and action, and for the ecology of movement then music therapy provides a coherent sensory world of time and space (Aldridge 1996).

Emotional expression and relief

Depression and anxiety are increasingly being mentioned as major debilitating factors of neuro-degenerative diseases. Music therapy is a known anxiolytic and also improves mood. Furthermore, emotions can be expressed in satisfactory forms that need not be brought into words. For the verbally inarticulate, and those challenged by language when it is failing, other expressive forms are potentially of great value for the sufferer and their caregivers.

Quality of life

An improved communicative ability, coupled to a regained identity, where some movement is retained, or even regained, and a possibility of satisfactory positive emotional expression will promote an improved quality of life. If isolation is a major contributory component of emotional distress (Aldridge 1998; Aldridge 2000b), then the creative arts therapies will offer methods by which sufferers can experience their remaining potentials and communicate with others.

**References**


EU Politics
Round Table in Naples

Monika Nöcker-Ribaupierre and Chava Sekeles (Education/Training), Jos De Backer (Registration), Helen Odell-Miller (Supervision), Gianluigi Di Franco (President) and Gro Trolldalen (Vice-President).

In order to get music therapy accepted as one of the European recognized health professions, the subject of this round table was to talk about institutionalizing the EMTC, with a view to representing our profession in Bruxelles, and developing quality standards for training, registration and practice. This roundtable was intended to start the official discussion about our future, our priorities, goals, and strategy, with the hope of encouraging music therapists from all over Europe to actively support these efforts.

During the last few years we have learned that to be recognized as a serious partner in the EC and in particular to be able to receive official financial support from the EC, we need to represent our profession in Bruxelles, that means to incorporate ourselves as an official association under Belgian law and to register this association with the Belgian authorities.

The round table: At the beginning we saw the overheads of several questionnaires we did in 1996 – 1998 in order to enlighten the variety of the music therapy landscape: country organizations/members, training courses, registration, protection, practice after diploma and payment. These data were of course obsolete – and they need to be regularly updated! – but they show the difficulty to compare the status in the different countries.

After this introduction, each of the participants gave a statement of her /his ideas and visions for future action. We talked about institutionalizing the EMTC, and the necessity of developing quality standards for training, registration (example UK) and practice. That means, we talked more detailed about the future-paper that I had presented during the opening session (see attachment for asbl)

Summary:
During these statements and the different questions from the audience it became very obvious that the decision of „going to Bruxelles“ and developing the political aspect of music therapy will demand a big effort, mentally and also financially. To get an idea and find a suitable pathway through the political and social structure of the EC we will definitely need help from professionals (lobbyist), which is only possible with the support of the national organizations.

At the end, Chava Sekeles read her vision of the future of music therapy – a vision we should keep in mind while working on the political aspects of our future.
Visions for EMTC

“We must achieve European recognition as a profession and move into adulthood as a profession. Here in the UK we have state registration now. It felt like a big step and it took a lot of very hard work. I feel we have come of age in the UK now. We are into adulthood as a profession. This also means that we are regulated by law as a profession, which places our responsibility to work within ethical and professional boundaries in a larger perspective.”
Julie Sutton/UK

“Future is only assured with quality standards for our profession. Therefore we should work as strong as possible on registration for European music therapists.”
Jos De Backer/B

“European level registration of music therapy profession. The profession should be recognized as a Health Care Profession. In order to make this possible we need minimum standards and criteria for music therapy trainings.”
Heidi Ahonen Eerikainen/FI

“I dream of a minimum standard for music therapy training. I dream of a fluency of teachers and staff from country to country. I dream of the possibility of supervision for every music therapist. I dream of project working in music therapy among a lot of European countries.”
Gro Trolldalen/N

“Music therapy is a recognized and protected profession like speech therapy or physiotherapy and is situated like speech-therapy within health and educational system. For EMTC a good working together and supporting each other with help of further education, common professional politics and information.”
Heidi Fausch/CH

“... more cooperation among different European countries
... if the child music therapy is growing up towards the adult life, please don’t forget you were a child
... establish in a general but representative way different standards, mostly on deontological and professional aspects
... if the music therapy starts from the music, please, don’t make that the words will submerge its reason why it exists.”
Gianluigi di Franco/I  

"Strengthen European network of music therapists –  
* Facilitate the exchange of information of music therapy in the European countries through internet -  
* Develop and expand the existing cooperation and communication between national music therapy organisations – professional associations as well as societies -  
* Enhance communication between music therapy practitioners and researchers and inform about present research projects. For all countries to have easy access to this information -  
* Exchange of information on training courses, other relevant courses and events of interest for the European music therapy community."

Helle N. Lund/DK

"More described and defined music therapy methods, in several languages but in English to be informed internationally, on the development of evaluations and effects."

Almut Pioch/NL

"Improvement of communication, specially to deal with different ideas and conflicts, and transparency. And to spread out significance and importance of the EMTC throughout the countries – like it has started with help of the website."

Regina Halmer-Stein/A

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**The future of music therapy**

Chava Sekeles  
ISRAEL 2001

I wish to keep seeing future candidates of music therapy, for whom music is the core of life, and for whom musical expression is a natural language.

I hope continuing seeing each patient as a unique world and not as an example of standard diagnostic categories.

Leston Havens writes in his book "Approaches to the Mind" (1973: 17), that in some professions, awareness of uncertainty, complexity, instability, uniqueness and value conflict, have led to the emergence of professional pluralism; or, as he called it "The Babble of Voices". Indeed, in music therapy, as in the fields of psychotherapy and even in medicine, there is a certain vagueness and complexity. This vagueness can be attributed to the fact that in therapy we deal with "a universe of one" as Erik Erikson defined it in "The Nature of Clinical Evidence" (1958); and due to the fact that translation of musical phenomena into words does not yet transmit its intrinsic meaning. However, vagueness, complexity and acceptance of one’s self as not being omnipotent, are not signs of weakness but rather of self-reflection and of positive criticism. Personally, I wish to sustain this feeling till my last professional day. At the same time, I am aware of the fact that in some therapists it creates an urgent necessity to seek
proof. To prove your own worth, to prove the scientific value of the profession through research etc.

Indeed, research is very much needed in our field, either done by music therapists, music-medicine researchers or other relevant professions. The question is "What kind of research do we want and need"? Personally I would prefer research dealing with the quality of the therapeutic process. In other words an Action Research which grows from within the profession. In addition, as an enthusiastic traveler after the origins of the profession I would like to go into more and more depth into our roots in integrative research to maintain some of the naivety that characterized the formal beginnings of music therapy in the fifties and sixties. In Israel, as in many other countries, we have traveled through a long route in the last 37 years; a route of quantitative and qualitative development. We have an umbrella association, 250 music therapists, several schools, a journal, international connections etc. Still, I wish we could revive some of the enthusiasm and goodwill of the pioneering days to keep as far as possible from political evil spirits and collaborate positively within the diversity and variety of our therapeutic approaches.


Kunsttherapie in der Onkologie: Ergebnisse einer Literaturstudie

Christine Jakabos und Peter Petersen*

Einleitung


Aus solchen Überlegungen heraus schien es sinnvoll, die Publikationen zum Thema „Kunsttherapie in der Onkologie“ systematisch zu untersuchen.

Ergebnisse der Literaturstudie


Die weitere Aufgabe bestand darin, wenigstens stichwortartig eine Vision für die Methode zukünftiger Studien zur Künstlerischen Therapie zu formulieren. Für die verschiedenen Untersuchungsschritte dieser Studie geben wir in diesem Essay nur

* aus dem Forschungsinstitut für Künstlerische Therapien (Leiter Prof. em. Dr. med. Peter Petersen) Kauzenwinkel 22, 30627 Hannover

Das erste Kapitel „Grundlagen“ beleuchtete zunächst folgende Fragestellungen:

- Welche grundsätzlichen Anschauungen gibt es in kunsttherapeutischen Schulen, wie z.B. Jungianer, Psychotherapeuten, Anthroposophen? Wie sind diese in der Onkologie vertreten?
- Ist diesen Anschauungen in der Publikation explizit eine praktische therapeutische Bedeutung zugeordnet? Welche?
- Wie ist der derzeitige Stand auf dem Gebiet der kunsttherapeutischen Forschung zu beurteilen? Im einzelnen: Welche Prinzipien wissenschaftlicher Forschung können zugrunde gelegt werden? Welche Forschungsansätze finden sich in der Kunsttherapie? Was sind die maßgeblichen Inhalte der kunsttherapeutischen Forschung in der Onkologie?

Das zweite Kapitel „Darstellung“ befaßte sich mit der wissenschaftlichen Praxis der Dokumentation therapeutischer Prozesse:

- Wie genau ist ein einzelner therapeutischer Prozeß beim individuellen Patienten dargestellt?
- Wie ist die Methode der Darstellung? Welcher Umfang betreffend die Patientengeschichte liegt im Aufsatz, bzw. im Buch vor?
- Wie ist die Darstellungsmethode zu bewerten: auf der einen Seite hinsichtlich ihrer Unterscheidung von der üblichen medizinischen Erfolgsstatistik, auf der anderen Seite, was die Berücksichtigung von Ergebnissen bisheriger kunsttherapeutischer Forschungstätigkeit anbelangt?

Die Entwicklung von Anforderungen an eine möglichst genaue und übereinkommende Prozeßdarstellung, eine konsekutive Bewertung der erbrachten Leistungen, sowie eine Untersuchung von strukturellem Aufbau und Gewichtung der Veröffentlichungen und ihre Eignung für objektivierbare Reflexionen und Vergleichbarkeit mit anderen Patienten bildeten den Schwerpunkt der Arbeit. Der

Dem dritten Kapitel „Die Autoren“ liegt zunächst die Fragestellung zugrunde:

- Welcher Art ist das Selbstverständnis des Autors, und wie gliedert er sich in Kultur und Wissenschaft ein (Beruf, Tätigkeit, evtl. wissenschaftliche Ausbildung)?

Des weiteren war die Frage nach Stellungnahmen der Autoren zu folgenden metatheoretischen Aspekten von Interesse:

- Formuliert der Autor einen Wissenschaftsbegriff von dem er geleitet ist?
- Formuliert der Autor ein Menschenbild, insbesondere Reflexionen über die Arzt-Patient-Beziehung (z.B. hinsichtlich Übertragung und Gegenübertragung) und über die Auffassungen von Krankheit und Tod bei Therapeut und Patient?
- Resultiert aus den Ausführungen des Autors eine Outcome-Definition, oder wird sie gar konkret formuliert? Dieser letzte und wichtigste Teil des Blocks sollte klären, wie der Autor, bzw. Therapeut seinen Erfolg bemißt, wie er also z.B. den Gewinn für die Lebensgestaltung des Patienten definiert.

Das zusammenfassende Ergebnis dieser Studie besteht in einer Interpretation zu der übergeordneten Frage:

- Ist ein Zusammenhang zu erkennen zwischen dem Menschenbild, das der Autor zum Ausdruck bringt, und der Methode der Darstellung, welche er für seine Veröffentlichung gewählt hat?

Diese abschließende Diskussion und Schlußfolgerungen und Ausblick bezüglich zukünftiger Perspektiven wissenschaftlicher Vorgehensweise in der Kunsttherapie bilden die Quintessenz der Arbeit.

Der vorliegende Artikel kann lediglich einen knappen Einblick in die Ergebnisse der Arbeit gewähren. Deshalb soll im folgenden nach einem kurzen Überblick der Kern der Arbeit, nämlich die Untersuchung der Patientengeschichten fokussiert werden.

48 von insgesamt 83 Veröffentlichungen, die einer genaueren Untersuchung unterzogen werden konnten, vertreten einen psychotherapeutischen Ansatz, der im weiteren Sinne der humanistischen Psychologie zugeordnet werden kann. Weiterhin vertreten werden ein rein anthroposophischer Ansatz, die Verknüpfung kunstpädagogischer Aspekte mit psychotherapeutischen, der Integrative Ansatz, die Verknüpfung kunstpädagogischer Aspekte mit einem anthroposophischen Ansatz, ein rein kunstpädagogischer Ansatz und ein heilpädagogischer Ansatz.

Für den Großteil der Autoren, namentlich für die Vertreter des psychotherapeutischen Ansatzes, konnten weitere relevante Bezüge herausgestellt werden. An erster Stelle ist die Beschäftigung mit Prozessen der Krankheitsbewältigung zu nennen. Aber auch diagnostische und prognostische, also im weiten Sinne analytische Arbeit, auf psychischer wie auch auf somatischer Ebene findet zahlreiche Vertreter.

DIAGRAMM 1: Unterschiedliche Ansätze der Veröffentlichungen zur Kunsttherapie in der Onkologie.

Das folgende Diagramm veranschaulicht, welche weiteren Bezüge für die Vertreter des psychotherapeutischen Ansatzes relevant sind.

**DIAGRAMM 2: Nähere Spezifizierung des psychotherapeutischen Ansatzes**

Die im Diagramm zu den einzelnen Balken angegebenen Werte beziehen sich auf die Anzahl der entsprechenden Veröffentlichungen.

Die einzelnen Balken repräsentieren folgende Bezüge:
3. In 37 Veröffentlichungen gehen die Therapeuten analytisch vor im Sinne diagnostischer und prognostischer Zielsetzungen.
5. In sieben Veröffentlichungen wird die Visualisierungstherapie nach Simonton als Methode autosuggestiver Einflußnahme auf physiologische und pathophysiologische Abläufe eingesetzt.
6. 24 Veröffentlichungen weisen explizite Bezüge zu C.G. Jung auf,
7. fünf zu Sigmund Freud.
8. 41 Veröffentlichungen formulieren Krankheitsbewältigung als ein Hauptanliegen (in Anlehnung an das Phasenmodell nach Elisabeth Kübler-Ross oder in Beziehung zur Coping- und Lebensqualitätsforschung).


Ein großer Teil der Autoren stellt Betrachtungen bezüglich typischer psychodynamischer Konstellationen und Persönlichkeitsmerkmalen in Assoziation zur Krebserkrankung an. Diese Auffassungen gründen auf Forschungen der medizinischen Psychologie, die lebensgeschichtliche Gemeinsamkeiten von Krebspatienten zum Inhalt haben, und auf Forschungen der Psychoonkologie, die sich mit typischen Konstellationen der Persönlichkeitsstruktur befaßt.


Die grundsätzliche Verknüpfung kunsttherapeutischer Forschung und naturwissenschaftlicher, bzw. medizinischer Forschung erscheint gerade auf dem gemeinsamen Sektor der onkologischen Therapie für beide Seiten als potentiell entwicklungsfördernde und daher auch erforderliche Perspektive: Der besondere Augenmerk muß sich auf die Verbesserung von Krankheitsbewältigung und Lebensqualitätserhöhung der Patienten richten. Offensichtliche

Verschaltungsmöglichkeiten bilden die Soziologie, die Psychologie und die Psychosomatik.

Neben Versuchen der theoretischen Anknüpfung an die genannten Gebieten liegen als ausdrückliche Forschungsunterfangen der Kunsttherapie in der Onkologie aber noch weitere Arbeiten vor. Diese untersuchen jedoch in keinem Fall die Ursachen von Phänomenen. Vielmehr richten sie ihr Interesse auf das vorangehende Stadium von Forschung, nämlich auf die Frage:

- Welche kunsttherapeutischen Phänomene sind vorhanden und wie sind sie beschreibbar?


Angesichts der unterentwickelten wissenschaftlichen Gegenstandsbildung in der Kunsttherapie sollte bei der Auswertung von Fallgeschichten folgende Frage bedacht werden:

- Welche Phänomene werden von den Autoren der Fallgeschichten zur Kunsttherapie in der Onkologie tatsächlich beobachtet und beschrieben, wie werden sie beschrieben? Was erhält den Rang eines Phänomens?

Eines der Probleme bei der Erforschung therapeutischer Prozesse ist die Tatsache, daß gerade konkrete, sinnlich wahrnehmbare, persönlich erlebbare, bedürfnisrelevante Gesichtspunkte den essentiellen und tragenden Anteil von Therapie darstellen. Der Kunsttherapeut als Forscher kann also solchen subjektiven Wahrheiten gar nicht „unverdient große“ Bedeutung beizumessen: Er selbst gestaltet entscheidend Bedeutung und Intensität der Begegnung mit und verleiht dadurch solchen Fakten ihr individuell angemessenes und besonderes Gewicht. Der


Obwohl die meisten Dokumentationen kunsttherapeutischer Erfahrung aus dem klinischen Bereich stammen, in dem interdisziplinäre Kommunikation die Effektivität der Arbeit beeinflußt, schlägt sich dieser Aspekt nur durch zwei Veröffentlichungen interdisziplinärer Arbeitsgruppen nieder (Herrlen-Pelzer et al. 1998, Stålhammar et al. 1997).

Künstlerische Bildung, Anteilnahme und folglich eine hohe Achtung für den Wert und die Bedeutung der eigenen Erfahrung werden zwar von vielen Autoren benannt, bilden sich im Großteil der Quellen jedoch nicht ab. Weder finden sich entsprechende Reflexionen, noch werden von den Autoren Standpunkte hinsichtlich ihres Wissenschaftsbegriffes und ihres Menschenbildes formuliert, denen die Attribute „produktiv“ oder „kreativ“ verliehen werden könnten,- Attribute, auf die Künstler eigentlich einen Anspruch erheben sollten!


Auffallend ist, daß zwar einige der Autoren das Interesse auf Ursache und Wirkung von Kreativität lenken, sie aber nur auf dem Niveau rein spekulativer Äußerungen einen knappen Standpunkt dazu formulieren. Demzufolge mußte eine eingehendere Untersuchung des Kreativitätsbegriffes der Autoren vollständig entfallen. Die


Der folgende Tabellenaufbau erwies sich als Basis für eine vergleichende Auswertung der kunsttherapeutischen Patientengeschichten als praktikabel:

**AUSWERTUNGSTABELLE 1 (Kopfzeile):**

<table>
<thead>
<tr>
<th>Biographie (Anamnese)</th>
<th>Einstellung (initiale Rk.)</th>
<th>Befinden psych. som.</th>
<th>Pat.-Zitat (Bild/Outcome)</th>
<th>Bildserie (mind. 2)</th>
<th>Vorgehen (des Pat.)</th>
<th>Reflexion (Gefühle)</th>
<th>Planung (Intention)</th>
</tr>
</thead>
</table>

Erläuterungen zum Verständnis der Tabellenstruktur:

Jeder veröffentlichten Fallgeschichte wurde eine Zeile in der Tabelle zugeordnet, so daß durch eine graue Unterlegung der einzelnen Tabellenzellen die enthaltenen Informationen zu folgenden überschriebenen Kriterien übersichtlich markiert werden konnten:

1. **Biographie (Anamnese):** Enthält der Text biographische oder anamnestische Angaben über den Patienten?

2. **Einstellung (initiale Reaktion):** Gibt der Text Auskunft über die Einstellung des Patienten zur Therapie, d.h. über die Erwartungen, die der Patient an die Therapie stellt, seine Motivation oder seine Reaktionen auf therapeutische Maßnahmen?

3. **Befinden (psychisch/ somatisch):** Ist in der Darstellung der psychische bzw. somatische Zustand des Patienten festgehalten?

4. **Patienten-Zitat (zu Bild/Outcome):** Beinhaltet die Darstellung wörtliche Wiedergabe von Ansichten des Patienten zur Bedeutung der Bilder oder zum persönlichen Gewinn, den er aus der Therapie gezogen hat? (Dieses Kriterium wurde auch als erfüllt gewertet, wenn der Autor seine Darstellung explizit auf detaillierte Therapieprotokolle stützt, seine Kommentare also die Zusammenfassung eines dokumentierten therapeutischen Gespräches sind.)
5. Bildserie (mindestens zwei): Sind dem Text mindestens zwei Werke des Patienten beigefügt, die also zumindest einen Schritt des Arbeitsprozesses im Sinne einer Veränderung oder eines Fortschrittes dokumentieren könnten?


7. Reflexion (eigene Gefühle): Sind die eigenen Gefühle und Reaktionen des Therapeuten dokumentiert oder gibt er zumindest eine weitere Auseinandersetzung mit dem Fall an (außer der Tatsache der Veröffentlichung)?

8. Planung (Intention): Ist ein geplantes, strukturiertes aber zugleich individuell flexibles Vorgehen des Therapeuten insofern einzusehen, als er mindestens eine spezielle Zielsetzung formuliert oder eine spezielle therapeutische Maßnahme erläutert?

Dazu führen wir etwas genauer aus:

1. Die biographischen und anamnestischen Angaben über die Patienten sind in ihren Inhalten einer starken Variationsbreite unterworfen, die durch die differierenden Anschauungen und Zielsetzungen der Therapeuten begründet werden könnte.

2. Fast alle Autoren äußern sich zu den Erwartungen oder anfänglichen Reaktionen und Einstellungen ihrer Patienten in bezug auf die Kunsttherapie.


7. Wenige Autoren/Therapeuten bringen sich selbst in ihre Falldarstellung ein; sie erscheinen dadurch unsinnigerweise wie ein „allwissender Erzähler“, der über


Die Kontinuität therapeutischer Prozesse war in sehr wenigen Veröffentlichungen nachvollziehbar. Jedoch war diese Kontinuität bei folgenden Autoren erkennbar:


Waser (1990) legt eine ausführliche Monographie vor. Als Psychiater und Psychotherapeut arbeitet er auf der Grundlage der Analytischen Psychologie nach


Die Schlußfolgerung liegt nahe, daß es weniger bestimmte Termini oder Formulierungen sind, die dies ermöglichen, als vielmehr die besondere Methode der Darstellung. Nur eine Erzählung ermöglicht es dem Autor, zwischen den Zeilen zu schreiben, und dem Leser, zwischen den Zeilen zu lesen, was für sie jeweils als ausschlaggebende und nicht verbalisierbare Information erscheint. Hier bietet sich im Hinblick auf die Weiterentwicklung der Darstellungsmethode eine Anknüpfungsmöglichkeit an die Literaturwissenschaft.

Insgesamt drängte sich bei den Recherchen die Vermutung auf, daß auf dem therapeutischen Sektor verschiedensten Natur- und Geisteswissenschaften, aus entgegengesetzten Richtungen kommend, versuchen, identische Phänomene zu begreifen. Es scheint sich nicht ausschließlich um ein terminologisches Problem zu handeln, das die unterschiedlichen Disziplinen voneinander abschottet; im wiederholten Durchscheinen und Auftauchen des Begriffes „Mystik“ deuten sich nach unserer Ansicht zwei fundamentale und evolutionäre Erkenntnisse an:
Die Fähigkeit zu Hingabe und Versenkung wird als essentieller Anteil menschlicher Existenz erkannt, und nicht mehr als überholtes, schwächlich anmutendes Bedürfnis nach Religiosität in einem Atemzug mit antiquierter demütiger mönchischer Selbstgeißelung verspottet.

Die Formen des Denkens und der damit notwendigen neuen Ausdrucksformen scheinen vor einer Pforte zur entwicklungs trächtigen Eruption anzudrängen.

Ein wesentlicher Aspekt für eine wissenschaftliche Prozeßdokumentation der Kunsttherapie in der Onkologie läßt sich so formulieren: Im Zentrum kunsttherapeutischer Forschung stehe derzeit nicht die Systematik von Modellen, sondern die Deskription und Rekonstruktion der therapeutischen Abläufe in einer geeigneten und angemessenen Sprache (Petersen 1990). In der Lyrik wird die durch das lexikalische Verständnis der Wörter aufgenommene inhaltliche Bedeutung des Textes vielfach überlagert von sprachlichen Auffälligkeiten, die vom Leser mit Sinn aufgeladen werden. Dieser Vorgang der Semantisierung findet auf mehreren sprachlichen Ebenen statt. Dies ist kein Vorschlag, den in Balladenform verfaßten Fallgeschichten Reim und Metrum zugrunde zu legen, es sei denn, der Autor empfindet dies als angemessen. Gemeint ist hier der Einsatz sprachlicher Technik, sozusagen literaturwissenschaftlicher Erkenntnisse zur optimierten Vermittlung und Rezeption verdichteter Informationen.

Umberto Eco (1973) äußerte sich in einem Aufsatz zur poetischen Funktion der Sprache, also zu ihrer Verdichtung, wie folgt (gekürzt durch Jakabos): „Als dichterisch gilt für gewöhnlich jene Redeweise, die, zugleich mit einer bestimmten Bedeutung auch eine neuartige Emotion vermittelt; und dies so sehr, daß die Emotion auch dann entsteht, wenn die Bedeutung nicht sofort klar wird.“ Ein Beispiel:

Du klar-frisch-süße Quelle,
Darin die schönen Glieder
Die Frau getaucht, die mir gefiel wie keine.

(Gedicht von Francesco Petrarca, deutsch von Benno Geiger, nach Eco 1973)

Dieses Beispiel zeige, daß die Originalität der Organisation, die Unvorhersehbarkeit in bezug auf das Wahrscheinlichkeitssystem der Sprache, zu einem Zuwachs an Informationen führen kann. Undzweir zu einem Zuwachs derjenigen Informationen, die der Verfasser wirklich vermitteln will: die Essenz einer subjektiven und situationsgebundenen Wahrheit. „Dem Liebenden [in diesem Gedicht] gelingt es so, zum Ausdruck zu bringen, daß er sich erinnert und noch weiterhin liebt, und dabei die Stärke seiner Liebe durch die heftige Bewegung dieser empathisch sich äußernden Erinnerung selbst mit der Unmittelbarkeit einer gegenwärtigen Anschauung zu verdeutlichen.“

Interessant erscheint uns in diesem Zusammenhang die Frage nach Perspektiven für die Entwicklung von Ausdruck auf der einen, und von Rezeption und Wahrnehmung

Bevor allerdings die Kunsttherapie Perspektiven für die Entwicklung eines angemessenen Ausdrucks für die Phänomene in ihren Therapien ausbauen kann, muß sie zunächst ein vereintes tragendes Fundament hierfür evolviert. Eine solche Grundlage, auf der möglicherweise sogar die verschiedenen Ansätze kooperieren und kommunizieren können, bildet die anzustrebende Einigung und Schulung von Rezeption und Wahrnehmung im Hinblick auf die zu klärenden spezifischen künstlerisch-therapeutischen Erscheinungen.

**Literatur**


Ch. Jakabos: Kunsttherapie in der Onkologie- eine Literaturstudie, Dissertation Medizinische Hochschule 2000


Zusammenfassung
Music therapy in the rehabilitation of children with cochlea implant (CI)

Karen Radbruch

When I speak about music therapy in rehabilitation for children with cochlea implant it is necessary to characterise the context first of all. After the operation with a cochlea implant deaf or rather high grade hearing impaired children gain at least some physiological hearing abilities and the condition of learning to hear is created. Some children have for the first time a hearing experience. Rehabilitation in this context means to company and to support the slow growing into the world of sounds and voices. They have to make up the same steps of development as children do without a hearing loss - just a few years later. Our job is to bear in mind this natural development and to create conditions to help these children to make the essential experiences on their way. An interdisciplinary team works together, and what is interesting is that a music therapist is seldom part of this rehabilitation team in Germany. But nevertheless we find several fields of work within this process, in which music plays a major role: musical speech therapy, listening training with music instruments, musical rhythmic education and last but not least music therapy. In practical work it is not always possible to draw a clear dividing line between all these working fields and it is even not possible to define a general, standardised concept for music therapy.

When working with children my intention is to get in contact and to communicate with them via the medium of music. This kind of communication happens in a very playful way. At the beginning there are no specials rules or exercises. The children might try whatever they like to and what comes to their mind. Thus, children have the opportunity to discover their personal
creative skills. During this period, I try to take up their musical offers, to reply them or to continue them and to build up a first contact. It is important to emphasise the concept of musical activity as a joint activity. I am just another player with equal rights, I am not the leader, who in advance knows what will happen next.

I would like to characterise the situation as a sort of “musical playground”. Hearing impaired children are involved in trainee programs quite often, doing a lot of exercises to improve their hearing and speaking abilities. I think that the playing character of music therapy can be a nice contrast. Learning and discovering by playing is a natural way of learning in the development of children and we must pay attention, that these children don’t forget to play.

When I started working with cochlea implanted children I often began with a welcome song with piano accompaniment or I added wonderful harmony chords to the first musical activities of the children. But these children were not really enthusiastic! Some looked somehow afraid, others looked just bored. These activities already make great demands on the children’s ability to hear. For children who stand at the beginning of a hearing process and who get in contact with music probably the first time this might ask too much of them and a welcome song with piano accompaniment might be characterised as “language with disturbing factors and interference”. Therefore, I prefer a more basic first contact with music: music that is simply and clearly built and does not frighten the children. From this starting point the musical activity can become more complex and be developed together with the children.

To find out their individual hearing needs we have to watch the children and their reactions attentively. They often show their needs quite clearly!

For me it is important in music therapy that children have the opportunity to discover instruments and sounds themselves (– even if it is not always easy for a music therapist to keep out of the process in the beginning!). However,
to start music dialogue and communication, children need to perceive themselves as creators of sounds and must get used to hearing all these different sounds of the instruments.

**Goals of music therapy when working with children with cochlear implant**

- For cochlea implanted children the first goal of music therapy on their way to the world of sounds and voices might be to awaken an interest in musical instruments and to explore the instruments as sound-instruments.

  I have met several children, often short time after the CI-implantation, who were quite interested at the instruments – but they were fascinated by all the screws of the drums, they discovered the letters written on the xylophone and arranged the same letters together or they reflected their faces in the metal of the trumpets. But they were not really interested in playing these instruments in the way we used to do it....

- If we succeed to develop an interest at the sounds of the instruments the children can discover a great variety of sounds and timbres. The high intensity and the huge frequency of music makes the perception of music somehow easier than the perception of language; hearing impaired people are more easily reached by musical sounds.

- Following this idea, a further aim of music therapy is that the process of learning to hear is supported and encouraged not only by discovering, but also by distinguishing, identifying and understanding. Focused listening as a first step, focused listening to another person as a second step are preconditions of effective mutual communication and we should not forget that the children have to make these basic experiences after an cochlea implantation.
The ability to hear can’t be conveyed in an isolated surrounding – it is only in a stimulating environment where a child is actively listening.

- An important fact is, that the auditory perception in this case is closely linked to their actions - children can search actively and are not just passive consumers.

- Another goal for the children with CI is to discover their individual voice in a new way. They can play and experiment with their voice, without the demands of speech and articulation.
  “A baby with hearing impairment does not hear his own voice. It doesn’t play with its voice like it plays with its feet and its hands” (HILDMANN, 1999, S.30). After the implantation the children have to catch up on this experience: playing with their voice, screaming, squeaking, howling. And we can work with all these sounds in a musical way: every voice has its pitch, its dynamic, probably its rhythm. So we accept it as a musical offer and work and play with it in a musical way.

- What is also worth mentioning is the fact that children find a new way to bring emotions into a form of expression – children who are in majority of cases limited in their development of speech and sometimes hardly find a way to express emotions. Music can have the function of a emotional “outlet”.

- Moreover, children might experience music as something positive and stimulating that enriches their way of perception. The promotion of personal musical abilities can be supported. A new self-confidence in musical abilities can be established and fears might be overcome.

- I personally think, that the most important aim is the communicative aspect of music therapy with cochlea implanted children, which is communication that is not linked to normal speech communication and
can be orientated at the age and the developmental abilities of each child.

Since the last point mentioned is the central aspect of my research I am working on, I would like to focus on the topic of communication.

**Communicative development**

The communicative development in children, with regard to children who can hear as well as those who suffer hearing deficits, starts very early in their lives. Already in the preverbal phase, a small child gains important communicative skills while interacting with the person to whom the small child relates most closely. Not only is the child’s day often structured by the parents but also interaction and communication, which, later on, leads to the acquisition of language.

If a child is hearing impaired, interaction between the child and parent is made more difficult. It is not the hearing impaired person who is hindered to communicate with the outer world, but rather his way of interacting with the hearing world. Verbal and non-verbal communication between the hearing impaired child and its hearing environment can not succeed completely and often much more effort is needed.

A large amount of psychological research has been done on the topic of the communicative development and behaviour of hearing impaired children (for example NICHOLAS, GEERS an KÖZAK, 1994: “Development of Communication Function in Young Hearing-Impaired and Normally Hearing Children”. LEDEBERG EVERHARDT, 1998: “Communication between Deaf Children and their Hearing Mothers: the Role of Language, Gesture and Vocalisation”). Those investigations mostly come to the conclusion that the communicative development of hearing impaired children progresses slowly concerning the
quality and quantity aspect of development (with the exception of deaf children of deaf parents). In my assessment it seems to be important in this context that verbal communication is always based on non-verbal communication. The research mentioned above also support this fact.

When working with children after the CI-Implantation, the learning of speech is central – but it should again be mentioned that non-verbal communication is the basic issue. The dependence of verbal communication upon non-verbal communication is always present.

“Several contemporary theories of language acquisition hold that the functional aspect of communication is the driving force in the acquisition of a formal language.”(NICHOLAS, GEERS, KOZAK 1994, S. 39)

The development of communicative skills is also fundamental for the social development of the child and is a key role for social integration. I am still not talking about the acquisition of speech but rather the acquisition of communicative skills.

To support and stimulate communicative development, it is necessary, as already mentioned, to focus on playful communication and dialogue, both meeting the needs of hearing impaired children. While doing so, the child’s personal stage of development, its hearing abilities and age of hearing should always be taken into consideration.

Through experiencing a positive and relaxed communicative situation, children gain personal strength and develop a sense of curiosity and joy for interaction and last but not least a motivation.

Improvised music offers possibilities for extremely varied communication, not merely linked to language components (s.a. ALDRIDGE, 1996, S.51ff).

Since 1999 I have been doing research on exactly this topic, namely to examine the components of communication development within the work of
Music therapy with hearing impaired children with a particular emphasis on communicative development

The intention of my study is to find out whether communicative behaviour of children significantly changes within 10 sessions of music therapy. The following questions are always present:

- Does the length of the interactive phase between child and therapist change?
- What is the relationship between the communicative modes “alternation” and “co-activity” in the interactive phases?

This differentiation and division of those two communication modes is based on the theories of DANIEL STERN. In 1975 he found in the non-verbal communication between mother and child two parallel modes of communication:

- the co-activity, where mother and child vocalise at the same time. It is indicative of emotional tone and promotes mutual experience.
- the alternation, which has a dialogical structure and which is important for the exchange of symbolic information.

We can find both modes of communication in improvised music.

- At least the focus on the “initiatives for communication”, which means the varying offerings made by both players in the interactive phases that brings the other partner into communication. Does the number of the initiatives changes and does the relationship between the initiatives of the child and the therapist change?

It would be taking things to far in this research to evaluate all sessions according to those questions; therefore I will only focus on 2 episodes in the
first, fifth and tenth session. Each episode is about two minutes and contains two examples of the longest phases of interaction between child and therapist in each session.

In co-operation with a special education development program for hearing impaired children up to the age of 6 years in Bochum and the kindergarten for hearing-impaired children in Bochum as well I have been working with 24 children between the age of 3 and 6. 11 of them have a cochlea implant, the others normal hearing aids. These children are part of a special program but previously have never had experience with music therapy before. Children with additional impairments were excluded from my research.

I would like to present to you two little boys and take concrete examples from their therapies to explain the results:

Marvin is four-year-old boy, very friendly and calm, a little dreamer, who likes to be by himself. He is untiring in his actions if left alone. When Marvin was one year old, a severe hearing impairment bordering deafness was diagnosed in both ears. When he was three and a half years old, he got a CI. Three months later I got to know him in music therapy. The following sentences are taken from his file: “Marvin shows a passive communicative behaviour within the verbal level... Changes in play were only noticed sporadically.”

In the first music therapy sessions he was interested at the music instruments in his own way: he touches and examines them, especially the screws and fiddled around with the drumsticks. There is only some play activity and little interest for me. Moreover, there seems to be no interest in the instruments concerning sound. The first instrument he uses a little bit longer in the first session was the triangle.

Let’s have a look at the beginning if this improvisation:

Marvin has chosen the triangle. He plays the triangle and observes how the instrument moves – he is fully concentrated and thrilled.
I play the piano – like him with high pitch. I try to follow his playing, I try to imitate it.

A focused listening to his own instrumental activity starts – a focused listening to me is one step too far and so there is nearly no place for musical interaction for the moment.

In the 10th session we start sitting there with the congas; an interplay develops and there are long moments in which I have his full attention. Marvin realises my musical offers and he is able to response appropriately. In addition to that he brings his own ideas into the common play. Such a phase of directed concentration is something special for Marvin at this time.

Marvin is one of the children in the research whose phases of interaction have become much longer. In a chart this change of behaviour looks like this:

\[ \text{Transparency 1} \]

This result explicitly proves that during these musical activities Marvin has discovered and enlarged his way of interacting and has made basically experiences concerning his communicative development: as we find the
ability to listen and respond appropriately to sound, which is a vital aspect of communication.

Until now I have done this evaluation with the videos of 9 children with cochlear implants and regarding this group we find 6 other children with the same tendency concerning the phases of interaction. All these 6 children I met in their first 18 months after the operation of the CI.

A second result of this evaluation is the structure in which Marvin plays within the interactive sessions:

*Transparency 2*

![Marvin: "Interaction/Structured play"

This interaction bases on the structure of alternation which seems to be plausible considering Marvin’s hearing age.

All the 6 children, where we find an increase of phases of interaction, started musical interaction in a dialogical structure, although this mode of
communication is not always as dominant as we find is in the development of Marvin.

“...the establishment of dialogical structure, that in itself enables meaning to be negotiated, is the first important step in communication”. (ALDRIDGE 1996, S. 36)

Completely different are the results of the second child I will show to you now:

Niklas is a 6-year-old boy. He is tall, full of energy and has broken three drumsticks during those 10 sessions while playing the drums ...

Niklas’ high grade severe hearing impairment was diagnosed when he was four months old. At the age of three he got a CI, which he didn’t accept at the beginning, but finally did half a year later. When I got to know Niklas he had already had the CI for two and a half years. From his file I get the following information: “Niklas knows about the communicative character of language and tries more and more to use this language.”

Let’s have a look at the graph showing Niklas’ length of interactive phases:

Transparency 3
A lengthening of the interactive phases can’t be observed – the tendency is even contrary. 3 children of the study show no clear change concerning the length of the phases of interaction. All of them had the CI for one and a half year or more. There is only one child where the interactive phases are definitely shorter in the end.

However, there is a change in Niklas’ communicative behaviour. I would like to illustrate this by referring two examples from the first and tenth session:

Niklas starts playing the drum very loudly and powerfully, I sit at the piano. He makes short breaks and waits for my entries. He gives the initiatives, I imitate his instructions. Twice I make him an offer, but he doesn’t seem to notice it. He seems to be quite astonished when I go on playing the piano without making a break. He waits till I finally make a break to go on with his drumming.

The next example belongs to the 10th session:
I play 2 congas in a regular, slow metre. Niklas sits down at the piano and starts to play in my tempo – we play together for a while. Then I start playing very soft and he does the same. He imitates my way of playing and finds out alternative ways of playing the piano. At the end the communicative mode changes again an we play together strongly – interrupted by joint breaks by a show of hands.

I think it is very plain, that the quality of interaction has changed in between the first and the second example and in addition Niklas has found a individual way of creation and expression in musical activity. In the first session it was Niklas who determinates the interaction and the mode of communication was exclusive the alternation.

In the 10th session we find both modes of interaction, co-activity and alternation. This leads me to the assumption, that the quality of partnership has changed.
Interaction is not only the imitation of a special number, of a special dynamic or tempo. Interaction has become more and more flexible and free. It is not so static as it was in the beginning.

Furthermore the mode of co-activity makes higher demands on the ability of hearing. Niklas has to follow the sounds of two different instruments simultaneously.
In a chart this change looks like this:

7 of the 9 Cochlea implanted children in this study showed a changing concerning the modes of interaction.

In the 10th session we secondly see that both players give initiatives and react on the initiatives of the partner as well. An equal partnership has developed.
This development I want to show you with the help of another graph: . Here we can see the number of initiatives, offered by Niklas and by the therapist, that brings the other player into communication.

Transparency 4
In the work with hearing impaired children I often observe an imbalance between the two communication partners: some of them dominate the interaction completely in the beginning, others only react or imitate for a long time what I play.

8 of 9 cochlea implanted children in this study showed a changing concerning the relationship between the initiatives of child and therapist.

A “healthy” interaction requires that there is a sense of action and reaction from all participants involved. For children who have just received the CI, interaction on a verbal level is almost impossible – but via the medium of music it is easier to connect and find an appropriate level of communication. Children experience active parts of interaction; they feel how to react and to lead. They make the experience of autonomy in an interaction.

Communication is never static. Strict exercises with fixed rules would never come close to what is typical of an interaction, namely that something develops in an unexpected way and permanently changes. This is the reason why I mostly avoid hearing exercises. It must be observed, however, that a completely spontaneous unstructured activity might be too much for some of the children, without at least some guidance and rules.
Thinking of the results of the research study and thinking of all the my experiences in the work with the children I know for sure that music therapy can be a useful and increasing supplementation in the rehabilitation of cochlea implanted children.

We will never replace neither the speech therapy nor any other profession in the program, but we can give the children useful and essential experiences on their way to the world of sound and voices and to the world of verbal interaction and communication.


Aesthetic Perspectives in Music Therapy

Isabelle Frohne - Hagemann

Abstract:
Aesthetics have to do with how we perceive and evaluate the "world" (our experiences). From a philosophical perspective, little research has been done so far on the subject "Aesthetic" in music therapy. This is surprising, as different theories of aesthetics have a fundamental influence on music therapy. They reach from metaphysical to physical and from anaesthetizing to aesthetizing positions.

A short discussion on the history of aesthetic theories from Plato to modern philosophers may help us to better place the different explicit and implicit philosophies and theories that are used by modern music therapists in order to legitimate their music therapy approaches. With regard to the development of a basic theory of music therapy it might be helpful to work out a meta-theory of aesthetics that music therapists can refer to.

It could be interesting to have a look at the aesthetic dimensions of music therapy since it is in this field that various theories are applied that correspond with different historical periods. It may be instructive to relate the aesthetic positions of the last 2500 years and music therapy today, to provide a new and better aesthetic motivation to this kind of therapy and promote an evolving development.

The history of aesthetics is perhaps not as much a history of art than a history of the "body" (German: Leib). Aesthetics have to do with the awareness of having a body and being a body. One could assume it as the history of suppressing our bodily condition or, on the other hand overstressing the importance of the ego.

1 In integrative music therapy the concept of "body" (Leib) implies the body (the pure matter), the soul and the spirit, all of them mingled with the surrounding environment. We are not connected to our ecological environment only through the food chain but also through our belonging to the so called "social worlds" whose components taught us how to think, feel and act. The "body" includes all this. An American colleague once told me that in English it would be better to add "The person in the world" to the word "body". Or maybe the person seen as a bio psychosocial being or as an ecological being? I will put the word body in inverted commas when the concept of the "Leib" is meant.
It is necessary at this point to clarify the notion of aesthetics. We generally mean in common language something else than "bodily" perception. Our perception is related to objects as for instance a nicely prepared table, a stylised Japanese garden. A well proportioned woman body is regarded to be aesthetic as well as a dance with harmonious movements. In these cases the aesthetic element emerges from an element which improves a trivial phenomena. It is called the "improving element" (Welsch, 1996, 24).

Aesthetics in its philosophical history was meant as an embellishment, a creation of objective art work and therefore as a way of mastering the world outside. The idea that the word aesthetics comes from "aisthesis" ("bodily" or sensitive perception) was not considered as essential although the "body" is man's only organ for perception and cognition!

It was only with Feuerbach and Nietzsche that these concepts started having such a meaning attached to them (cfr. Jung, 1994; Petzold, 1985).

Where is the world created and formed? Our "body" is the place where this happens. An aesthetics starting from the "body" in the sense of the "body" as a "complete sensorial organ", to quote Merleau-Ponty (1945) did not exist.

The perception of the external reality was referred to what is behind the material world, the metaphysical part - from Plato to Romanticism - or to the subjective perspective - during the Romantic Age. Either Materialism or Idealism but without any exchange processes between these two positions.

And even today man does not consciously consider his "body" as a place of aesthetic knowledge. On the contrary, the more the body (here: the pure matter) is the focus of attention, the more our "bodily" dimension is neglected; the more the body is made aesthetic the more it is made anaesthetized.

In the digital era human body (meant as the body that we have but not the one that we are) appears more and more unnecessary (who needs a body in order to chat on the Internet?), but as in fact we need the body as a necessity as long as we live we try to dominate the body by programming and moulding it as we like. Today as never before our body is submitted to aesthetical treatments, massages and relaxing techniques in fitness centres, sport clubs and beauty farms, and it is adorned with dresses, tattoos, piercing and so on (Klein, 2000). With this body we present ourselves to the external world. Not "I am my body" (Marcel, 1985, but 15) I just possess a physical body. However, our "body" is still our total sensory organ through which we experience the world, get in touch with other people and live with heart and soul!

2 The concept of aesthetics derived from aisthesis and the "body" means that man takes much more into account his bodily relation towards whatever he creates. To create something does not mean to only focus on external rules of aesthetic beauty but to perceive and feel (through the "body") what a certain phenomenon (as for instance a musical instrument or a musical idea) causes in us as perceptions, thoughts, associations, memories, images, emotions, and so on. We then perceive, in turn, what comes out of the relationship between the "body" and the created object.
Now, if I really am my body and not only own one then I am identical with the entire world. This is because I keep in my body the history of my social life, the spirit of my time and I am mingled with the environment I live in. This is the social - ecological meaning of me being a "body". Therefore it does not make any sense just wishing to mould the "body" aesthetically. On the other hand, it does make sense to abandon oneself to the "body", and therefore to the world, and thus trust the flowing of our being.

Let's take the example of the improvisation used in music therapy. What matters is not as much the aesthetical representation of a form. The client does not have to play "well" but starting from an experience he is invited to follow the flowing of its becoming, to follow the sounds as they come out of him/herself and be surprised by the creative way in which they combine themselves and almost autonomously assume a Gestalt which unfolds its meaning only within this process. There is no reason to stick aesthetically to an externally established rule but it is the aesthetical process of GESTALTBNLUNG that matters.

Philosophical aesthetics in history

I would like to trace now, always making short comments on music therapy aesthetical dimensions, the course of the history of aesthetics which, from a very metaphysical position gradually and cautiously also developed a consciousness for the position of the 'I am my "body"' dimension. Today aesthetics does not refer only to the completed object but starts process from the of the "body" in resonance: it is the bio psychosocial "body" which perceives and resonates. Aesthetic creation emerges by responding to the resonances of the "body". Aesthetics is a process of continuous creation.

It was not always like that. Let's have a look at history (Helferich, 1998, 464; Hauskeller, 1999, 9).

Classical antiquity

In classical antiquity the aims of aesthetics were the recognition of divine perfection, truth and good. The aesthetic issue was also an issue of epistemology. Issues pertaining to philosophical aesthetics became only part of the figurative arts, because art was able to represent reality visually and what one believes is generally considered more true than that which is felt through other senses.

According to Plato the experience of beauty had an educational function. Art should not rouse our senses or excite our emotions. On the contrary it should teach man how to control his emotions and live a virtuous life and be inclined to truth. Aristotle's, on the other hand, said that strong excitement, if

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3 With reference to the Gestalt psychology, a Gestalt is something more and different from the sum of the different components. A Gestalt is a continuous process in which the components relate to each other and to the whole. A subject will respond to the whole as an entity as well as to the parts. In fact it responds to the movements and relations.
experienced in the right place at the right moment could by all means have a moral value and be compatible with mind. Art was mainly seen as a valve of affect and one should be in touch with it in a correct way. As in Plato's opinion art served to metaphysics. In the world of art one was to meditate about ideas and the senses were to be domesticated.

Such an aesthetic position, defined by W. Welsch as a "metaphysical position", was present throughout classical antiquity. Despite of a passionate admiration for everything spiritual, it is a basically anti-sensory position. The senses and the "body" are actually a means to pass from sensory experiences to extrasensory ones. Therefore, the metaphysical position is essentially an "anaesthetizing aesthetics" (Welsch, 1990, 27).

We find such a metaphysical position also in music therapy when music is used to transcend and/or dominate our drives rather than to express our personal emotions. It is present when music is used in order to arrange and structure the soul and the client is to follow the music as his/her teacher. We can find the same position not only in some music therapy conceptions, as for instance Anthroposophical Music Therapy, but also in GIM or in Analytical Music Therapy, or whenever that we deal with the concepts of transcendence or sublimation.

We could reproach Freud for not having valued drives and the Id, because he wanted to submit them to the Ego. According to Freud being sensory should be sublimated. This can make sense in many cases but each music therapist has to ask himself/herself whether he/she uses music in order to restrain or to increase the "body's" wisdom and whether the sense perception itself is sufficiently valued as a subject of reflection.

**Medieval aesthetics**

Back to history. In medieval aesthetics the purpose of art was not only to highlight beauty but also to show the essence of the invisible in through the visible, that is to reveal divine signs to the world. What could not be perceived by the senses, was to be represented aesthetically using light and colours, thus through sight. The invisible needs symbols in order to be represented. This explains the wide use of symbols and allegories not only in the pictorial arts, but also in music.

What cannot be perceived by the senses certainly is much more interesting than that which can be perceived. In music we perceive not only sounds but also take into the awareness energy fields and relations (Zuckerkandl, 1963) which refer to symbolic meanings. They also play an important role in music therapy. However, as for the interpretation of symbols and a general interpretation there are different trends. Among music therapists some scholars consider the aesthetical representation and interpret the extemporary work of art according to certain theoretical criteria while others prefer to concentrate on the aesthetical processes as for instance intensifying,
widening, shortening, distorting, sharpening, inverting, merging or transposing musical motifs, figures and forms in their relation to psycho dynamical processes. The second group is the one I prefer. Instead of trying to understand the symbol as an accomplished piece of aesthetical presentation I try to understand the symbolization. Symbolization is a way to create Gestalt configurations and an aesthetic dimension used f. ex. in Morphological Music Therapy (according to Salber, 1991, 6 Gestalt factors). Here the process of transformation is more important than the created product.

Two dimensions concerning aesthetical perception come clearly out: some music therapists focus on the music as the accomplished creation of patients while the others highlight the act of creating in itself. As far as I know this last aesthetic position did not matter in the past.

Renaissance

Up to the XV century visible objects were considered as signs of a divine invisible reality. During the Renaissance, instead, objects now expressed themselves. If an object was considered beautiful, this meant to acknowledge the structural laws expressed by its appearance. Artists started to apply the laws of perspective. Things can appear smaller or bigger, thinner or larger, clearer or darker. Indeed, the discovery of perspective established a relationship between the object and the observer, the eyes. However, aesthetic perception remained fixed on the object and was still basically visually oriented. There was no awareness of the sensory resonance of the "body" on the perception of the object.

It is necessary to underline that the western aesthetics with its concepts of experience and truth has been and still is strongly influenced by the Greek "theoreo" (I see). Cognition, and therefore theory, are connected to the eye which is as part of the brain. This might be the reason why aesthetics were mostly applied to the pictorial arts and not so much to music. Aesthetical concepts like vision, gaze, survey, perspective, lightening and so on have a visual nature and convey a different kind of knowledge if compared with the sensory knowledge of hearing, feeling, touching and tasting. This second kind of knowledge has a "bodily" nature based on feelings, contacts, empathy and resonance. What is the difference between "hearing some voices" and "have some visions"? The answer is that somebody who is "hearing voices" is regarded to be a psychiatric case, whereas a person "having visions" could be qualified to become a candidate at the State General Elections. The valuation of the importance of the eye goes along with a narrow-mindedness for the other senses which means a reduction of knowledge!

Romantic Age

During the Romantic Age in the XVIII century an aesthetics of feeling (Shaftesbury, Hutcheson, Burke) became to appear. What was perceived as beautiful could be considered as such, apart from the objective appearance of
the object. The romantic approach which put human feelings on the foreground was prevailing. The "felix estheticus" became the new ideal of man (Welsch, 1990, 28). This was the period when in 1750 Alexander Gottlieb Baumgarten in his work "Aestetica" (Schweizer, 1988) reconsiders the meaning of aisthesis from which he takes the concept of sense perception and sense cognition. Man should become aesthetical himself through the arts. Such a conception could make us believe that man's sensibility, sensitivity and the wisdom of the "body", thus aisthesis, was to be recognized.

But it was not like that. The "education of sensitivity", meant as an "ennoblement", to quote Schiller, marked the ultimate detachment from the primary sensory condition (Schiller, quoted in Welsch, 1996, 117). According to Schiller (1759 - 1805) art shows man what he could become, by realizing his becoming a complete being through playing. "Man is a complete human being only when he plays" (Schiller, quoted in Fricke, Göpfert, 1984, 618). However, Schiller did not mean by playing a free game, or what is considered today a free improvisation, but he thought that when playing we learn how to take possession of the "world", that is to mould it in order to possess it. He states that is necessary to modify everything actively in a way that nothing is as it was before but becomes as we want it to be (Schiller, 11. Lettera, 603). Schiller's theory reveals a lack of openness to submit oneself to an uncomplete process, to devote oneself to the subject and let us be changed by the material world. Schiller recommends, on the contrary, to control the material world. The world must be moulded and created without surrendering to it and its peculiarities. "Festgemauert in der Erden, Steht die Form aus Lehm gebrannt; Heute soll die Glocke werden, Frisch, Gesellen, seid zur Hand; Soll das Werk den Meister loben, Doch der Segen kommt von oben" (the burnt clay shape is walled up in the earth; today the bell will be moulded, my friends be ready to operate; if the teacher praises the work it is from above that the blessing comes) (Schiller, Die Glocke). This again is the situation of the traditional aesthetics.

We can see that the projects aiming at making the romanticism aesthetical did not recover the concept of aisthesis. If senses are only meant to serve for being educated and if they are not allowed to speak for themselves, it is better to become insensitive and anaesthetized. Music teachers at colleges of music teach their students not to sense their own feelings and not to express themselves with the unprejudiced enthusiasm children still have. The musician who is taught to restrain his abilities within the limits of aesthetical perfection will go to the doctor for inflamed tendons or to the psychoanalyst for being stressed. This is the other part of the process of becoming anaesthetized. Shouldn't there be a correspondence between sensing and moulding?

Also in music therapy there are therapeutical approaches based on the idea that everything can be treated by applying perfect techniques and rules that the patient's soul. If our Governments compels us to demonstrate the effectiveness of music therapy methods and techniques but at the same time they should accept the concept of "aisthesis" as a treatment tool. In therapy
there are illnesses which, according to modern aesthetics, cannot be solved if we do not give the client the possibility of coming to an understanding of his/her pain by aesthetically processing his/her own feelings, perceptions and actions. Play rules and tasks shouldn't be used as prescription but they should be offered as different experience fields within which the client experiments with the adequate aesthetical perspectives on his disturbances and where he/she is responsible for his willingness to give in aesthetical poiesis.

When we merely let us be moulded from an external norm, like Schiller's bell, we loses our "bodily" nature of perception and are forced to restrain our uniqueness. Our pseudo-aesthetical trend towards becoming aesthetical by moulding, absorbing and exploiting the world around us has devastating consequences: If everything can be made and moulded, nothing can possibly be felt in resonances and therefore nothing can be improved in an aesthetical process. What is left is a temporary kick out of it which leaves an empty space. Any perception is illusion and senseless without the ability of empathy and resonance. In my opinion, Schiller's idea of moulding oneself and the world by playing leads to nowadays conception according to which we strongly anaesthetize ourselves with everything aesthetical.

Already 200 years ago, however, it was Kant who indicated this different direction from the theoretical aesthetics perspective. In his Criticism of Reason (Kritik der Urteilskraft), § 9, (Weischedel, 1974) he claims that beauty comes from the "free game of cognitive abilities". A sensational statement! According to him beauty is not created out of the complete absence of rules but by the artist himself who introduces his own aesthetical rules.

Kant demonstrated that the basis of what we call reality is of fictious nature. We recognize only what we put into the things. But these recognitions are based on purely aesthetical suppositions (Welsch, 1996, 47). Nietzsche developed further Kant's knowledge: What we perceive as reality is based all together on aesthetical projections. Recognizing is therefore a mainly metaphoric activity (Welsch, 1996, 47).

This aesthetical turn has a remarkable influence on hermeneutic and diagnostic issues in music therapy (Frohne-Hagemann, 1999a, b). Aesthetical poiesis is continuous. This means that each acquired piece of cognition is just a temporary arrival point and at the same time the starting point of a new movement of aesthetical search (hermeneutics). Any explanation, any interpretation of a process in music therapy is a hypothesis that has to be verified.

The aesthetical turn started by Kant and Nietzsche prevents us from putting diagnostic statements on record. It is necessary to be very cautious with clinical stigmatisation by music therapy improvisation. Musical processes can indicate the texture and the activity of an illness (the process) but not a fixed classified disease.
Our clients' aesthetical way of acting is a creative process (nothing remains unchanged, everything flows), a free "game of cognitive abilities". According to Nelson Goodman, born in 1906, the world is created on the basis of our way of being related to it, and the way we are considering, defining and describing the world (Goodman, 1968, 242). We take actively part of the continuous creation of lived world. Therefore the how, why and aim of perception and cognition are much more important than the perceived object. Each aesthetical perception no matter whether it the "body" is consciously in action or not, is already an interpretation. What we consider true and real is only what matches our perceptive habits which can be very much different according to the moment and the culture we come from. When we interpret a music therapy improvisation we have to take into account our previous aesthetical and theoretical assumptions about (music)therapy. This is important because by interpreting we also produce new realities.

**Modern aesthetics**

Modern aesthetics changes from being "opinion (or attitude)" to being "(inter)action". Aesthetics means continuously to create and re-create. Understanding and creation go together. A modern aesthetical experience in music therapy is characterized by an exchange of a thinking that is sensed and felt and a feeling that is reflected by thinking and acting. This is the reference to the body.

**The body as a central concept**

Who has been the first in history to valuate the "bodily" sensory aspect and sensory cognition? Schopenhauer, Feuerbach and Nietzsche were the three philosophers who actually gave importance to the "body". Schopenhauer was the first to claim that the "body" is the foundation of cognition (Helferich, 1998, 340). Art can only portray the ideas (because, as I would add, it serves our sight) while music is an expression of our own will. If music is an expression of our will, we can assume that man is able to feel this will in himself. Therefore "bodily" perceptions, music and sensory cognition are in correspondence with each other. Such a "bodily"-musical correspondence (Frohne-Hagemann, 1999b) is for me of the outmost importance because it shows the possibility of recognizing ourselves in musical creations through our "bodily" wisdom. When I listen to music and experience it in an aesthetical way, the interpretation of such music is connected with my sensitiveness for the moment being, with my way of feeling and with my personal and cultural experiences. There is less projection on my side rather than creation.

**Expression** as a way of acquiring knowledge was essential also in Benedetto Croce’s opinion (1866 - 1952). We acquire the knowledge of something only the very moment in which we express a subjective feeling (Croce, 1930,4).

It is above all with Feuerbach (1985) and Nietzsche (1988, KSA 4, 15) that the dichotomy between physical body and spirit comes to be overcome.
Human "body" becomes a central concept without any metaphysical reference. Actually in the XX. Century aesthetics becomes more and more "physical" and therefore "lived world (lebensweltlich)" because the body is meant as "the person in the world". The "body" is the embodiment of the world in which we live. Aesthetics does not relate only to art but also to experiences in the lived world. Hence the experience of the "beautiful" arts expires. The integral world is completely out.

Free improvisation and non conventional instrumental sounds make also the cacophony to be appreciated since it is part of aesthetics just as is consonance and harmony. Healing means being able to look again into the abysses without suppressing the feelings connected to it and being allowed to express one's feelings.

In the middle of the last century Adorno (1903-1969) added an important aspect on the concepts of the aisthesis (Adorno, 1973, 53 and on). Art should not comply with today's "titty-tainment" (consumption of art and music as "suckling the tits" like a baby). It should not address unsatisfied people's need for entertainment. Aesthetical processes are not comfortable. What is clear and simple to understand cannot be defined as art, neither as, I would say, therapy. Music Therapy deals with the incredible and the extraordinary not only in the psyche but also in social life.

Moreover Adorno underlines the importance of the context and the critical judgement of social contexts and debates for understanding and interpretation. This is an aesthetical and gnoseologic dimension of music therapy that shows the importance to perceive the conditions of certain socially determined ways of life.

Finally I would like to take into consideration another existential aspect of aesthetics. We become more and more personally responsible of our way of life and in our search for a coherent identity we note that and how we submit to an ongoing process of aesthetical transformation. The more we undergo such a process the more aesthetics makes us confront with the incomprehensibility of being.

According to Jean François Lyotard, born in 1924, aesthetics deals with incomprehensibility meaning by that in the presence something can happen that the intellect cannot control (see Hauskeller, 1999, 95). Lyotard defines this quality as the Sublime. The Sublime is something too big and powerful to be completely understood by imagination. as Death is an example. Being obliged to stand the moment in which something happens or does not happen is terrible but healthy at the same time. When a client in relation to his/her therapist lets his own sensitivity and feelings develop an aesthetical Gestalt both do not know where this journey will take them. They abandon themselves to the mere present, and what is incomprehensible is this being in the here and now. The intellect has to confide completely in the "body" and "bodily"

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4 A world meant as individual, social and cultural realities experienced personally (Lebenswelt).
communication: a very important task from the point of view of commitment. It means to give up the anaesthetization of the body.

From the post modern attitude of stressing the unexpected and overcoming rigid rules follows that also the music therapist should be open to the possibility that an improvisation might not develop along the therapeutic lines he/she was expecting that it should or could.

Play rules should be considered as an open framework which can be abandoned each time it is needed for a single client in regard to his perceptions, feelings and actions within the therapeutic relationship.

To summarize: we have experienced in the history of aesthetics a development and the shift from a metaphysical position towards a physical orientation of aesthetics (in the meaning of "aisthesis") where the awareness of the process lies in the creation in itself.

However, in spite of such a shift the anaesthetizing process goes on spreading as a social way of anaesthetizing which leads to ignore the social needs. The results of modern aesthetical research do not find any resonance.

Could a music therapy code of aesthetical awareness possibly contribute to change this process? From the aesthetical point of view it would be a major social service given by music therapy, not only to people in need of being treated but also to each and everybody.
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Barcelona Publishers
Zuckerkandl, V.v. (1963): Die Wirklichkeit der Musik, Rhein Verlag
Dear friends and colleagues, here is the new website and the beginning of a new era. Dr. Jörg Fachner is to take over the editorial duties of the magazine “music therapy today”. Indeed, the idea for the title of the magazine was his and he will develop more new ideas for the magazine. He is also our in-house expert on “consciousness”, at least when he is awake, and will be working on our new in-house project for a systematic review of the music therapy literature.

The website “musictherapyworld” is now established as a sound information platform and we have a consistent number of subscribers everyday. We will be developing the online databases as before and if you read below you will see how we are planning new expert databases for particular areas of clinical interest. If you have any suggestions then please let us know, our aim is to provide music therapists, and those interested in music therapy, with comprehensive information about practice, research and education.

We have now installed a “newsletter” function for you to subscribe to “music therapy today” and also to let you know what is happening in the world of music therapy. Please use it and let your colleagues know about the magazine and the website. Simply link to “music therapy today” and click on the newsletter icon.

“music therapy today”

You will find new articles in the online magazine.

Research news  Analysing the music in Guided Imagery and Music (GIM): descriptive and structural approaches by Denise Grocke.

As you will know, Denise is President of the World Federation of Music Therapy and it is an honour to have an article from her. You will also find her complete doctoral thesis on our new Info CD ROM IV.

Training programs

Melissa Brotons write to us about POSTGRADUATE/MASTER’S PROGRAM IN MUSIC THERAPY at the UNIVERSITAT RAMON LLULL, Barcelona, Spain.

Melissa has an sound academic reputation for music therapy research and we are all looking forward to see how this exciting program develops in Spain.
Practice News

The Sound Path - Finding My Way in The Playground by Petra Kern

Petra is a research student of mine, so I am proud to be able to present a practice study that she has made. Anyone who has heard her speak will know that she is a fine example of how actual daily practice can be the foundation for exhilarating research studies.

Music Therapy as Complementary Medicine by Suzanne B. Hanser discusses the recent inclusion of music therapy into centers for alternative, complementary, and integrative medicine. For those of us involved in complementary medicines, now called integrative medicine, it is rewarding to see how music therapy is playing a significant role. Suzanne is Chair, Music Therapy Department Berklee College of Music and secretary/treasurer World Federation of Music Therapy and it is an honour that we can present her work here.

Aspects of music therapy in the Sozialtherapeutische Anstalt Baden-Württemberg and in the treatment of patients suffering from cardiac insufficiency as part of a training programme at the university hospital Heidelberg in cooperation with the rehabilitation clinic Kohlhof (Heidelberg) by Andreas Zeuch.

Forensic psychiatry is field of developing interest for music therapy and I am delighted to be able to present Andreas' work here.

For other practitioners in this developing field, please send us your contributions.

Systematic Review Project

Here at the University Witten Herdecke we are embarking on a new project to review the literature related to music therapy. The results of these reviews will be published as both papers and an online expert database. We have been fortunate to gain two new colleagues working on this project, they will be Markus Wenz – who will also organise our unruly archive- and Simon Gilbertson, who is our expert on music therapy in neurological rehabilitation.

This project is also in collaboration with the Professor Tony Wigram at the University of Aalborg, Denmark and Dr, Denise Grocke at University of Melbourne, Australia.

As you can see below, we are focusing on the following areas of interest initially.

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Guided Imagery and Music

Guided Imagery and Music

Forensic psychiatry and substance abuse

If any readers have PUBLISHED or UNPUBLISHED studies in these areas then please submit them to us for inclusion in the necessary databases. If you would like to begin a dialogues with us about any of these areas then please do so. My position is that we become experts through dialogue with practitioners and this project is one in which you can bring your knowledge. I am also interested in what patients and sufferers have to say about their experiences of music therapy, so if you have experience of music therapy at first-hand (or first ear) then please let me know.

I hope that you enjoy the online magazine and feel inspired to write to us with your contributions,

With best wishes,

David Aldridge

Chair of Qualitative Research in Medicine, University Witten/Herdecke.

Chair of Publications, World Federation of Music Therapy
Aspects of music therapy in the Sozialtherapeutische Anstalt Baden-Württemberg and in the treatment of patients suffering from cardiac insufficiency as part of a training programme at the university hospital Heidelberg in cooperation with the rehabilitation clinic Kohlhof (Heidelberg)

Aspekte zur Musiktherapie in der Sozialtherapeutischen Anstalt Baden-Württemberg und in der Behandlung herzinsuffizienter Patienten im Rahmen eines Trainingsprogramms des Uniklinikums Heidelberg in Kooperation mit der Rehaklinik Kohlhof, Heidelberg.

Andreas Zeuch

Abstract
The Sozialtherapeutische Anstalt (STA) Baden-Württemberg (institution for social therapies) offers a total of 61 places for approximately 6000 convicts in all prisons in Baden-Württemberg. Upon transfer, there is a rather wide range of therapies available to convicts: Single psychological therapy sessions, group therapy, environment therapy, work therapy, ergotherapy, kinesitherapy and music therapy. Convicts at the STA have been sentenced for a variety of crimes: Sexual offences, violent robbery, blackmail, attempted homicide and manslaughter.
The Sozialtherapeutische Anstalt (STA) Baden-Württemberg (institution for social therapies) offers a total of 61 places for approximately 6000 convicts in all prisons in Baden-Württemberg. Convicts who are either to be transferred as a consequence of the above-mentioned paragraph or have applied for transfer themselves, have to meet the following cursory criteria: they must be in need of and suited for therapy, capable of forming relations and reflection, not older than 40, must present no risk of intended escape, and apart from exceptional cases, not be in unlimited detention (unlimited detention being the maximum sentence in Germany: there is no final term pronounced by a court of justice, which would automatically end in release in case of average conduct. This type of detention can only be suspended by an expertise and a subsequent decision by the prison authorities.) Upon transfer, there is a rather wide range of therapies available to convicts:

- Single psychological therapy sessions
- Group therapy
- Environment therapy
- Work therapy
- Ergotherapy (ergotherapist employed by the institution), psychodrama (freelance therapist)
- Kinesitherapy (freelance therapist)
- Music therapy (freelance therapist)

Convicts at the STA have been sentenced for a variety of crimes:

- Sexual offenses
- Violent robbery
- Blackmail
- Attempted homicide
- Manslaughter

In June 1999, I was commissioned by the director of the STA to offer music therapy to convicts on an out-patient basis and am still working in this capacity today. In the pilot phase of the first half year, the budget covered four hours per week; licherweise gerade auch der an Kreativtherapien, da immer deutlicher wird, dass nonverbale Verfahren eine gute Ergänzung zu den bislang ausschließlich angewandten verbalen Psycho-therapien darstellen.


- Psychologische Einzelbehandlung
- Gruppentherapien
- Milieutherapie
- Arbeitstherapie
- Ergotherapie (besetzt durch eine fest angestellte Ergotherapeutin), Psychodrama (Honorarstelle)
- Bewegungstherapie (Honorarstelle)
- Musiktherapie (Honorarstelle).

Die Gefangenen der STA rekrutieren sich aus verschiedenen Deliktbereichen:

- Sexualdelinquenten
- schwerer Raub
- Erpressung
- versuchter Mord
- Totschlag

Seit Juni 1999 bin ich als ambulanter Musiktherapeut vom Anstaltsleiter der STA beauftragt, für die Gefangenen Musiktherapie durchzuführen. In der Pilotphase des ersten halben Jahres umfasste das Budget vier Wochenstunden, in denen zwei musiktherapeutische Entspannungs-
two music therapy relaxation groups with six persons respectively were provided in a monochrome monochord. Within a few weeks, the therapy sessions turned out to meet with considerable interest among convicts, which has remained unchanged until today. As a result of the mostly very positive verbal feedback after the actual relaxation phase of ca. 45 minutes, the idea emerged to develop a preliminary qualitative and quantitative self-evaluation study in order to gain more exact and - at least to some extent - scientific results. This orientative study was started on May 8, 2000 upon approval by the criminological service Baden-Württemberg.

The study design may be described as follows: Over a period of six months, all participants of the relaxation music therapy are interviewed who first join the (open) group and volunteer to take part in the study. This implies an automatic random distribution, as convicts receive this offer and may also apply for the therapy, e.g. upon recommendation by other convicts. The only interface is the adherence to criteria for indication and contraindication. There are two levels of data collection: first, there are three problem-oriented interviews based on three different dates: prior to therapy, after three months and upon conclusion of the research phase after six months. Secondly, all participants are requested to fill in a questionnaire at each session with eight questions, three of which are quantitative, in order to determine states before and after. The other five are freely worded questions to be answered individually. Participants are, e.g. requested to state their expectations prior to the session, in order to determine whether these were met or not, and to comment on contents. One example of a question for expectations:

Before: “Relief, pleasant, stress-free day”

After: “Well-being, spend the day after therapy without pain in the neck. I just feel great.”
Starting in May 2000, seven convicts have participated so far, two of them for now six months, so that they have concluded the research phase and their data are being evaluated. The study design is open for the time being, with an interim deadline scheduled for autumn 2001 to evaluate and compare the data of all subjects up to that time and to reconsider whether this preliminary study can be continued or the design has to be changed.

Music therapy sessions, merely receptive at first, were later complemented by an active music therapy group when the study started in May 2000. This is a group with four to five participants who either volunteered or were encouraged to participate. The methods employed comprise free improvisation with or without given themes and also clearly defined hypnosystemic interventions. The first group ended in December 2000, a second started in January 2001.

A peculiar feature of working in a social therapy setting is doubtless the double obligation therapists may perceive in this context: nowhere else is there such a well-defined, standardized assignment to therapists to replace a patient’s deficiency in handling conflicts by an effective conflict management, to exercise social control and at the same time to address convicts’ wishes and needs which appear useful from society’s point of view. A consequence of this institutional construction is a tremendous lack of trust on the convicts’ part: each new therapy group needs answers to their question as to what may safely be mentioned in group sessions without being used against them.

Therapy subjects currently address a convict’s individual therapy objectives negotiated upon assigning the therapy. There is an obvious tendency to balance rational and emotional elements. In other words: a majority of convicts have difficulties perceiving and/or expressing their own emotions. Frequently, unwelcome feelings like anxiety, grief or
rage are suppressed and ignored, which of course is often related to the offense in question. This is certainly no great surprise but rather appears psycho-logical.

Receptive music therapy in internal medicine (chronic cardiac insufficiency)

As part of the so-called cardiac insufficiency programme, a joint project of the university hospital Heidelberg and the rehabilitation clinic Kohlhof, I also employed the above-mentioned relaxation training in music therapy. This programme is a three-week training course for a group of patients with chronic cardiac insufficiency; they benefit from a medical-psychological approach with a focus on latest findings concerning a gradually increased exertion for this group of risk patients instead of the avoidance of stress recommended in the past. This approach is complemented by a rather comprehensive service of psychological counselling on relaxation techniques like PMR and AT, yoga, dieting and also music therapy relaxation.

References

Contact:

Andreas Zeuch, Winzerstrasse 10A, 69126 Heidelberg, phone: 06221-80 14 42; e-mail: a.zeuch@gmx.de; website http://www.a-zeuch.de

Ernährungsberatung und schließlich musiktherapeutischer Entspannung.

Literaturauszüge

(Footnotes)
1 Sicherungsverwahrung ist das in Deutschland höchste Strafmaß: es gibt keine gerichtlich festgesetzte Endstrafe, zu der die Entlassung im Falle einer durchschnittlichen Führung automatisch ansteht. Die Sicherungsverwahrung kann nur durch ein Gutachten und die anschließende Entscheidung der jeweiligen AnstaltsleiterIn aufgehoben werden.

Kurzbiographie

Short biography
Andreas Zeuch, born 1968, diploma in music therapy, non-medical practitioner (psychotherapy), coach in neuro linguistic programming and DIALOG adviser; employed by the university hospital Heidelberg, internal medicine ward II to design and coordinate an interaction and communication training programme in medical education. In addition, freelance music therapist (social therapy, Baden-Württemberg) and adviser/trainer in human resources. From March 1999, doctoral studies at the University Institute for Educational Sciences, Tübingen, on “Designing an intuition training programme for consultants and coaches in organizational management”. Letures, workshops, seminars.
Music Therapy as Complementary Medicine

Suzanne B. Hanser

Abstract
This presentation discusses the recent inclusion of music therapy into centers for alternative, complementary, and integrative medicine. In particular, it deals with the application of music therapy to oncology patients at a well-known medical center for cancer treatment. Further, it identifies some strategies which might be useful in developing music therapy programs and complementary medical programs at facilities where these treatments have not been accepted.

In the United States, the bastions of traditional medicine are being flooded with consumers demanding access to non-standardized forms of therapy to help cope with various types of physical illnesses. This presentation discusses the recent inclusion of music therapy into centers for alternative, complementary, and integrative medicine. In particular, it deals with the application of music therapy to oncology patients at a well-known medical center for cancer treatment. Further, it identifies some strategies which might be useful in developing music therapy programs and complementary medical programs at facilities where these treatments have not been accepted.

As the body of scientific research builds to support the effect of the mind on the body, the use of music therapy as complementary medicine is becoming more widespread. Complementary medicine, formerly known as alternative medicine, is the application of nontraditional treatments to aid in the healing process as a "complement" to more standardized medical practice. These therapeutic modalities are now achieving greater acceptance as an adjunct to medical treatment in the United States. Ironically, these "new" practices hearken back to ancient healing methods and treatments which have been practiced in other countries for many centuries.

The inclusion of music therapy as a form of complementary medicine is currently being researched in medical centers and training institutions as they seek the most effective services for their patients. It is noteworthy that the National Institutes of Health have established an Alternative Medicine Panel to sponsor research studies of these nontraditional therapies in the United States. As research evidence builds, acceptance increases and music therapy programs achieve greater recognition and prevalence.

The effectiveness of music therapy for oncology patients has been documented in numerous descriptive and experimental studies (Standley, 1986; 2000; Stan-
dley & Hanser, 1998). Jane Standley’s meta-analysis of research in medical and dental settings (1986) offers effect sizes for experimental studies which test the impact of music therapy. Her data offer objective documentation of the effectiveness of music therapy in a variety of settings. Her analysis enables clinicians to benefit from research performed around the world. In her summary of the evidence, the following findings have tremendous implications for clinical music therapy:

“Women respond to music with greater effect than do men… Children and adolescents respond with somewhat greater effect than do adults… Music has slightly greater effect when some pain is present… Music seems to become less effective as the pain increases… The least conservative measure of music’s effect is patient self-report, while systematic behavioral observation and physiological measures result in similar, but slightly more conservative effect sizes… Live music presented by a trained music therapist has a much greater effect than does recorded music. Preferred music has the greatest effect…”

(Standley, 1986).

Deforia Lane’s psychoimmunology study (1991) is another landmark piece of research, identifying significant changes in salivary immunoglobulin A (said to be a measure of immune function) for oncology patients as a function of music therapy. This study led the way in its identification of an important physiological marker which could discriminate the changes which occur in music therapy.

The presenter has been delivering music therapy services to adult oncology inpatients at Dana-Farber Cancer Institute and Brigham and Women’s Hospital since the summer of 2000. This pilot program paved the way for its inclusion in the Leonard P. Zakim Center for Integrated Therapies, established in November, 2001. The Zakim Center currently offers the following clinical services:

- A Qi Gong research protocol
- Therapeutic touch
- Creative arts therapies
- Acupuncture
- Music therapy

Individual music therapy was available at bedside to patients who were referred by their physicians, nurses, social workers, psychologists and other medical personnel. Patients were referred for pain management or stress reduction. In addition, patients who were having difficulty coping with their illnesses or treatment and required a way to express themselves and communicate their feelings were also good candidates. Patients who lacked sources of social support also benefited from the individualized nature of this service. The only contraindication for music therapy was a major hearing deficit. Musical skills or background were not prerequisite. However, people who listened to music regularly and were able to identify concomitant changes in their moods found music therapy particularly appealing. They were also able to apply the coping strategies learned in music therapy sessions easily to their daily lives. Family members
and significant others also participated in the music therapy sessions, finding a way to share a creative, positive experience with a loved one while feeling better themselves.

In the fall of 2000, as part of their field work requirement, Berklee College of Music music therapy students assisted the music therapist in leading groups of outpatients. These weekly sessions were designed to teach patients relaxation and coping strategies through listening to live music and engaging in improvisation.

At the first meeting, the music therapist greeted each patient and introduced ways in which music therapy could be helpful. The patient’s musical interests and background were explored, and the Music Therapy Initial Assessment was completed as the therapist observed and questioned the patient. In discussion with the patient, objectives were set and music therapy techniques were sampled. When appropriate, family members were consulted and invited to participate in sessions.

The therapist selected from the following basic techniques to meet the established objectives:

I. Music-facilitated stress or pain management
   This was performed with live music, primarily on lyre, recorder or keyboard. The therapist followed a stress reduction protocol and offered assistance to the patient in selecting music which help them cope with pain or anxiety when the therapist was not present.

II. Music listening and expression of feelings
   This technique offered patients an opportunity to talk about what was happening in their lives, experience the pleasure of listening to music, reminisce, or discuss the memories and ideas elicited by the music.

III. Making music
   This incorporated singing, simple accompaniment and other opportunities to communicate, express and engage in familiar, comforting and creative activities.

IV. Improvisation
   Playing simple tuned and percussive instruments enabled individuals to use expressive media to communicate nonverbally.

V. Composing
   Song-writing and musical improvising helped communicate and express thoughts and feelings.

The duration of each session varied, dependent upon the patient’s stamina, interest, attention and desires. The therapist asked patients how they felt at the conclusion of the session, using a visual analogue scale for pain and comfort.

In this way, patient satisfaction and improvement in anxiety and locus of control were evaluated by self-report. These data will be useful in developing clinical music therapy protocols for future research. The goals of music therapy were threefold: to improve patient care, to educate future therapists, and to document the outcomes of music therapy, eventually through controlled clinical trials.

A significant concomitant to music therapy services was in-service presentations to medical staff to acquaint them with the service and instruct them in the criteria
for identifying potential referrals. The music therapist attended hospital rounds and other activities to inform and educate staff. Music therapy groups were offered to staff to reduce stress and enhance their working environment.

Out of this experience, the presenter developed some guidelines for clinicians who are interested in establishing music therapy services at medical institutions

I. Know the Lingo
   Read brochures about current services being offered.
   Learn the system in order to determine the role of music therapy amongst existing services.
   Identify the decision-makers who would determine whether or not music therapy is a viable service at this institution.

II. Know the Research
   Quote Standley’s findings
   Refer to Lane’s psychoimmunology research
   Know the music therapy and medicine literature

III. Know Your Community
   What services exist in your community?
   What services are needed in your community? Is there access to music therapy?
   What services are sought by patients in their recovery?

IV. Inform Others
   Volunteer to educate patients by offering classes in some music therapy techniques which they can use with consultation from a music therapist.
   Deliver staff rounds to educate service providers about how music therapy can assist them in meeting patient goals.
   Visit support groups to understand patient needs and to inform them about services like music therapy which hold many benefits.
   Donate library resources, such as publications which demonstrate the effectiveness of music therapy techniques.

V. Find Support
   In the United States, the American Music Therapy Association publishes several materials which present ways in which music therapy services may be reimbursed by insurance companies.
   Grants, available through foundations, corporations, individual sponsors and other funding mechanisms, may support the establishment of new services, such as music therapy.

VI. Write a proposal which meets the following criteria:
   Succinct
   Speaks to needs
   Addresses cost-effectiveness
   Identifies outcomes

VII. The following Proposal Outline is standard:
   Introduction
   Service
Clearly, the potential for developing music therapy services in centers for alternative, complementary and integrative medicine is great. As the medical arena across the globe opens to new “old” forms of treatment, the challenge is placed on music therapists to document the effectiveness of our services. We have an opportunity to become integrated into established and nontraditional medical practices in centers worldwide. We can take on this challenge with confidence and data in our pockets along with hundreds of years of experience using music to aid the ill.

Short biography

Suzanne B. Hanser, Ed.D., MT-BC
Chair, Music Therapy Department
Berklee College of Music
1140 Boylston Street
Boston, MA 02215 USA

secretary/treasurer World Federation of Music Therapy

Readers interested in music therapy and complementary medicine will find more articles in the archive on this website and an electronic book:

Aldridge, D 2002
“research in complementary therapies”
published in “music therapy world”
university witten herdecke online at http://musictherapyworld.net

and on the new info cd rom iv 2002
to be presented at the Music Therapy World Congress in Oxford, 2002.
The Sound Path - Finding My Way in The Playground

Petra Kern

Abstract
The goals of the project were to make his playground be a good learning environment for a blind child. A part of the Center is a childcare program that enrolls about 80 children from 6 weeks of age to 5 years old.

Goal of Intervention
Because he appeared unhappy and fearful on the playground and because music therapy has these potential benefits, the following goals were established.
1. To make the playground a useful place for children with visual impairments.
2. To design the playground so that it would be motivating and engaging place for children with disabilities
3. To design the playground to promote a variety of development skills such as social and communicative interaction, motor skills, and self-expression for all children.
4. To apply music therapy principles in designing the adaptation of the playground and to uses an integrative therapy approach.

The Sound Path had positive effects on the child with visual impairment. Children with disabilities found a medium which attracted them and led to independent play. The Sound Path added music to the daily life of the children enrolled in the childcare program and addressed therapeutic goals. Music therapy plays a role on the playground using an integrative therapeutic approach.

Overview
The project I will discuss was done at a child care center. It involved a young child who was blind. The goals of the project were to make his playground be a good learning environment for him. I decided to adapt the playground by providing him with a path for moving about the large space, adding musical stations to the playground, and providing staff development to his teachers. I did a study to evaluate these adaptations, and I found that simply adapting the playground resulted in some benefits, but when we later taught his teachers what to do, we were able to meet the goals of the project. Although the playground was adapted for this one boy, there were benefits for his classmates—some of them had other disabilities and some did not have disabilities. I want to describe this project and then allow time for discussion.

FPG Child Development Center
The project to make a playground occurred at the Frank Porter Graham Child Development, which is a university research and training center at the University of North Carolina, Chapel Hill, USA. A part of the Center is a childcare program that
enrolls about 80 children from 6 weeks of age to 5 years old. About a third of the children have disabilities, and children with and without disabilities are in each class. The missions of the childcare program are to do research, train professionals, and demonstrate innovations. The childcare program uses an integrated therapy approach; that is, the therapy and other special instruction are done in the classroom. This is done to minimize the stigma and isolation from pulling children out of the classroom and to capitalize on naturally occurring learning opportunities (McWilliams, 1996; Wollery & Wilbers, 1994). In the past, speech-language therapy, occupational therapy, physical therapy, and special education were all done through the integrated therapy approach. The professionals in these disciplines consult with the teachers, and help the teachers implement activities and strategies based on the professionals’ disciplines. A part of this project was to take the knowledge and principles from music therapy, and through adaptation of the playground and staff training help the teachers improve the experiences for this blind child who had tremendous difficulty on the playground.

Participant

The participant for this study was a 40-month old African-American boy, who was diagnosed with congenital blindness, and was functioning at about the 2-year level based on the Wisconsin Behavior Rating Scale (Song & Jones, 1980). As it is recommended practice for child care programs, David’s class spent large blocks of time outside on the playground (Bredkamp & Copple, 1997). On the playground he appeared fearful, depended upon adults for guidance and interaction. Peers often ignored him and went about their play. He rarely engaged with materials, did not climb on the slide or climbing equipment, did not ride the tricycles, and did not dig in the sandbox. Sometimes he asked for a ride in a wagon or he pushed a toy shopping cart on a concrete track for riding tricycles. He frequently engaged in stereotypic behavior like rocking his body and shaking his head. Although this child was the primary participant in the study, other children with disabilities also had similar difficulty on the playground.

Goals of Intervention for Children with Visual Impairment

The difficulties David experienced on the playground are predictable. Children who are visually impaired have difficulty managing large, defined spaces (Warren, 1994). They also need input to reduce their “blindisms”; that is, their stereotypic behavior. In addition, input helps them reduce their echolalia (Warren, 1994). Also, they need interventions to promote interaction with others and to reduce their social isolation (Warren, 1994).
Why Music Therapy for Children with Visual Impairment?
Music therapy has a great deal to offer to children who are blind. For blind children, the auditory system is a primary source through which they connect with and understand the social and physical world. Sound can be used to provide feedback on children’s location, and can be used to promote independent movement from one place to another. Further, it may be possible to reduce blindisms through music and other sensory input. Echolalia may be modified by giving the repetitive pattern a different meaning through music. Also, music may be a means of increasing social interactions between children.

Goal of Intervention
Because he appeared unhappy and fearful on the playground and because music therapy has these potential benefits, the following goals were established.

1. To make the playground a useful place for children with visual impairments.
2. To design the playground so that it would be motivating and engaging place for children with disabilities
3. To design the playground to promote a variety of development skills such as social and communicative interaction, motor skills, and self-expression for all children.
4. To apply music therapy principles in designing the adaptation of the playground and to use an integrative therapy approach.

Research Study
These goals were evaluated through a research project (Kern & Wolery 2001). I observed David on the playground in the following areas: (a) his social interactions with peers and with adults, (b) his play and engagement with materials and equipment, (c) his movement on the playground, and (d) his stereotypic behaviors. The project progressed through three phases, the first was a baseline which was the playground before adaptations. The second was adaptations of the playground. The third was the adaptations of the playground plus delivery of staff development.

The Sound Path
I want to describe how the playground was adapted. The adaptations involved two major changes: One was putting in a
boundary to serve as a path for David to move around the playground. The second was building musical stations and placing them in logical locations on the playground (see Kern and Wollery in press). A map of the playground can be seen on the previous page. It was very large, had a long concrete track for riding tricycles and pulling wagons, a wooden play house, garden beds, large sandboxes, and trees for shade.

Sound Path Boundary
The boundary (109 meters) circled the central portion of the playground. It was made from plastic drainage pipe and was modeled on a guiro. This pipe was submerged about three-quarters of the way into the ground. A 4-wheel push cart was constructed for David to push. It had a rubber flap that produced a sound when he pushed it over the drainage pipe. This was done to provide him with auditory feedback about his movements.

Musical Stations
There were originally six musical stations and another is under construction. The six musical stations, with various hand-made instruments, were constructed from materials donated by local hardware stores and music shops (Martini, 1993). The Sound Path was installed on a special work day that involved parents and staff of the program. The instruments were accessible to all children, easy to play, and complied with safety regulations. The stations were designed to be multi-sensory by using different materials, shapes, and colors. The ideas proposed by Snoezelen (Hulsege & Verheul, 1998) for indoor multi-sensory stimulation rooms were integrated into the design of the stations. Recommendations for how to use the Sound Path to develop sensorimotor, social, cognitive and emotional skills were devised for each station.

Station # 1. The first station, Touch Board, was situated near the playground entrance. It consisted of a bamboo xylophone, jingle bells, rain maker, and a second set of jingle bells and bamboo xylophone—all of which were attached to the fence. It was set up to be a mirror image of itself.

Station # 2. This station was a Xylophone located near a large sandbox with climbing equipment. The xylophone was made of hardwood and had 11 bars. Each bar was painted either blue or green. The bars of the same color sounded harmonically together.

Station # 3. This station was a Taxi Stand. It had a child-sized bench and a trellis with a bicycle bell and a horn. Both the bench and trellis were painted yellow to simulate a taxi stand. This station was located near the tricycle track to attract peers and increase the probability of interactions.

Station # 4. This station, Sound Pipes, included seven copper pipes of different lengths and attached to the trunk of a
tree. The station was located at the tree, because it had a wooden bench around it. Teachers and children congregated at this bench to converse, interact, and rest.

Station # 5. This station, Triangle Tree, consisted of two large metal triangles hanging from the branches of a tree. These triangles were of different sizes to produce different sounds. This allowed the wind to activate them, but a metal mallet also is attached to the triangles so that they could be rung by an adult or by a child held by an adult.

Station # 6. This station, Bucket Drums, were attached between wooden posts in one of the sandboxes. The three drums were galvanized pails of three different sizes to produce different sounds.

Staff Development Activities
Although these adaptations were somewhat successful, my goals were not completely met. As a result, I conducted training for his teachers. This involved a verbal description of the musical stations with hands on experiences. I taught them the songs I composed for each station and gave them a practice CD. I gave them a printed description of “Things to do with the Sound Path”, developed by the interdisciplinary team of the center. I made specific suggestions about how to involve David in the musical stations. Finally, feedback was given in the form of additional suggestions to the team at the center (see Table 1).

Results of the Study
Statistical Data
The results of this study show that during baseline he had few interactions with peers, had some interactions with adults, rarely played with materials or equipment, he moved but did so without apparent purpose, and he had a lot of stereotypic behaviors. With the adaptation of the playground, there was little change in social interactions with peers, a little less interactions with adults, much more engagement with materials and equipment, a little less movement—but more purpose movement, and much less stereotypic behavior. After the staff development activities, there was more peer interactions, more social interactions with adults, more play and engagement, a little more movement, and less stereotypic behaviors.

Clinical Statements
Clinically, after the playground adaptations and staff development, he appeared more alert, was more responsive to adults, expressed his likes and dislikes verbally, seemed to be in a better “mood,” seemed to learn turn-taking with peers more clearly which is an important accomplishment towards greater socialization (Gourgey, 1998), was more willing to take risks—for example, he would change the direction of his cart when he ran into something, was less fearful, and seemed to like the other children more and liked being with them.

Role of Music Therapy in Early Intervention
These positive results were based on applying music therapeutic principles to a situation where a child was not benefiting from his usual experiences on the playground. This raises the question of what is the music therapist’s role in children’s services. I believe there are at least four possible roles we can play to improve the lives of children.

First, is our traditional role of providing
direct therapy to an individual or small group of children. We understand the benefits of doing this and how to do it.

The second role for music therapists is to provide a mix of direct therapy and consultation to the child’s teachers, parents, or other caregivers. This may allow the knowledge from our discipline to be spread to others; clearly they would not be therapists, but they may benefit from knowing what we have learned.

A third role for music therapists is to train practitioners from disciplines such as teachers or other therapists (speech, occupational, or physical therapists) and to consult with them about specific children. This is not a traditional therapy role, but may improve the services children receive in their usual environments. (The second and third roles are consistent with the integrated therapy approach that is used by other disciplines in helping children’s teachers).

A final role for music therapists is to conduct research in early intervention. The potential benefits of such research are twofold: we will acquire new knowledge that can be used for improving children’s lives, and it will provide our field with additional credibility when working with professionals from other disciplines.

Benefits for all Children
An interesting finding that occurred as a result of this project was that children other than David benefited. The following benefits occurred for all children.

1. The Sound Path added music to the

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**Recommendations to develop sensorimotor skills**
- Explore how the instrument can be played: hit, scrape, touch, and so on.
- Explore the material. Is it cold or warm, hard or soft?
- Can you make the sand jump on the bucket drums?
- Coordination: hit with left or right hand, one hand versus two hands.
- Use pre-composed finger games; for example, “Thumbs on the Drums” which was written for the Bucket Drums for distinguish finger movement.
- Listen to the short tone of the bucket drum. Compare it to a long hold tone of the Sound Pipes.
- Find the highest or lowest sounding bucket.

**Recommendations to develop social skills**
- Call and response game (e.g., hit the drums three times and wait for a musical response from the other players).
- Practice turn taking.
- Develop a group rhythm and integrate all players.
- Interact with a signal given by a player (e.g., “If we hear the Bucket Drums, we walk, if not we freeze.”).
- Move and dance to the tempo and sound of a player (e.g., walk with long steps—slow tempo accompaniment; walk with short steps—fast tempo accompaniment; walk on tip toes—high sound accompaniment; walk on your heels—low sound accompaniment).

**Recommendations to develop cognitive skills**
- Imitate a simple rhythm pattern.
- Speak your name rhythmically and give every syllable a beat.
- Facilitate story telling with the Bucket Drums (e.g., “Chicka, Chicka, Boom, Boom” by B.Martin Jr. & J. Archambault)
- Sing songs including playing the drums (e.g., “Beat, Beat, Beat the Drum! by M. Schnur Ritholz).

**Recommendations to develop emotional skills**
- Find a rhythmical expression for different emotions. Can you play happy, angry, or sad?
- Self-esteem: Be the signal giver or conductor.

Table 1. Example of Recommendations for the Bucket Drums.
children’s daily lives.
2. The teachers used the music stations to address goals of individual children with disabilities. For example, one child with cerebral palsy had a goal of grasping and releasing. Her teacher used the horn on the taxi stand to work on this goal.
3. Children tended to congregate at the music stations and this led to social interactions.
4. The music stations allowed children to make music and to express themselves through music.
5. The stations stimulated creativity in two ways. The children invented games with the stations, and they used them in their dramatic play, for example, they used the Xylophone as a boat and pretended to be on the ocean.

Final Conclusion
The Sound Path had positive effects on the child with visual impairment. Children with disabilities found a medium which attracted them and led to independent play. The Sound Path added music to the daily life of the children enrolled in the child care program and addressed therapeutic goals. Music therapy plays a role on the playground using an integrative therapeutic approach.

References


Short biography
Petra Kern, Dipl. Sozpaed., Music Therapist BVM, MT-BC. University of North Carolina at Chapel Hill, USA is a doctoral candidate under Prof. Dr. David Aldridge.
Address: 302 Saint Thomas Drive, Chapel Hill, NC 27517. Phone: 919 967 4827, Fax: 919 967 4827, email: PetraKern@prodigy.net

Analysing the music in Guided Imagery and Music (GIM): descriptive and structural approaches.

Denise Grocke

Abstract

In my study of pivotal moments in GIM, I was also interested to compare the selections of music that underpinned the pivotal moment for four participants. I was interested to see if there were common elements in the selections of music that were playing at the time the clients experienced moments that were pivotal. I needed a structural model that was relevant to the music used in GIM programs - i.e. music of the Western classical tradition, recorded on CD. I developed a Structural Model of Musical Analysis (SMM) to analyse these selections of music. The SMM contains a comprehensive list of music elements, with sub-sections. Elements 1-12 relate to music form, while elements 13-15 relate to interpretations.

In The Bonny Method of Guided Imagery and Music (GIM), clients listen to recorded classical music in a deeply relaxed state, during which visual imagery, changes in mood and physiological effects in the body are experienced (Bonny, 1978a, 1978b). A GIM session includes a time of discussion between therapist and client to decide what the focus for the session will be. Next the client is given a relaxation induction so that they move into a deeply relaxed state with eyes closed. The therapist then chooses one of the music programs (of about 40 minutes of music), and as the images start to flow, the client tells the therapist what is happening for them. The therapist makes interventions (asks questions) to encourage more detail about the imagery experience. The therapist also writes a transcript of what is happening for the client. At the end of the 40 minutes, the therapist brings the client out of the deeply relaxed state, and there is a time of processing the meaning of the imagery for the client.

One of the most interesting areas of inquiry in GIM, is to what extent the music influences imagery and mood of the client's experience? Goldberg has proposed a Field Theory of GIM in which the music is the central field (Figure 1).

In the Field Theory Model, music plays the central role, but it also engages the outer cycle of images and emotions. The
Music (M) may evoke emotion (E) which may lead to a sequence of imagery (I). Goldberg asserts “even though the music may recede from conscious awareness, the music continues to exert its influence by providing focus, emotional support, structure to the experience, and dynamic movement to the image” (1992, p. 10).

In my study of pivotal moments in GIM (Grocke, 1999) I proposed that the music may directly influence the imagery and emotion experienced by a client, but equally that the client’s imagery may have a life of it’s own. That is, when a client is fully engaged in the unfolding of an imagery sequence, it may be the dynamic of the image itself that evokes the sequence.

In order to study the influence of the music in GIM, I devised a descriptive method of analysis, whereby a phenomenological description of the music was placed alongside the written transcript of the client’s GIM session. The purpose was to see if the flow of the dynamic changes in the music showed a parallel flow of change in the imagery sequence.

First, I made a phenomenological description of the music describing the features that stood out as I listened (melodies, harmonies, rhythms, which instrument/s were playing, the dynamics and mood). This is the “Open Listening (subjective response)” in the Ferrara (1984) model of phenomenological analysis of music.

Second, I listened to the music again, while also reading the score of the work. I added to the Open Listening descriptions to help clarify aspects of the music which were evident on the score - the “Syntactical meaning” in the Ferrara model.

Third, I created sections in the music according to units of meaning (following Giorgi’s model of phenomenological analysis). For example, a unit of meaning might be the section of music where the first theme was introduced, or when there was a change in tempo, or variation in the orchestration of the piece. I assigned each unit as a Music Meaning Unit (MMU) and gave each MMU a title, or heading (Giorgi’s step 3).

Fourth, the written transcript of the client’s GIM session was placed alongside the description of the music. Particular care was taken to match any comments about the music that the therapist had made on the transcript, with the corresponding part of the music. For example a new theme is often noted on the therapist’s transcript, or an important rhythmic motif may be indicated.

Fifth, I created units of meaning from the client’s imagery sequence (as written by the therapist) according to changes in the content of the imagery, feeling tone/mood of the imagery experience, and other features. I assigned each section an Imagery Meaning Unit (IMU) and gave it a title, or heading.

Finally, I placed the music descriptions (MMUs) alongside the IMUs to determine any comparative features between the flow of the music and the imagery.

Table 1 shows the parallel analysis of
music description and client imagery for
the the first selection of music on the Transitions (Bonny, 1978c) program.

In this example there are several links between the music as stimulus, and the

**Table 1. Description of Strauss: Ein Heldenleben (excerpt) from Transitions program (Bonny, 1978) with Client’s Session Transcript**

| Strauss: Ein Heldenleben - part 6 (excerpt). | Transcript of imagery
(Comments in brackets are the therapists interventions)
Focus image: an object for the journey.(The client chooses a piece of bark from a tree). |
|-------------------------------------------|----------------------------------------------------------------------------------|
| MMU 1 - a call to adventure
The cor anglais motif is an arpeggiated ‘call’ - intervals of 4ths, 6ths and open octave over an even beat on the kettle drum. This is the Hero’s theme (Strauss’ description). At section 100 the violins enter with the 2nd phrase of the melody, while the cor anglais continues with the motif (like a call to adventure). The drum beat adds a sense of anticipation. At section 101, the horns take on the call to adventure, filling out the middle register of sound. | IMU 1 - A strong tree, and a sense of marching
A piece of bark from a gum tree.
The bark is 4” long. (feel like?) - rough and strong, nice to have in my hand.
Like marching in an army. |
| MMU 2 - romantic theme
At the Langsam section there is a change in time signature to 6/8, and key signature to Eb. A romantic theme (the Hero’s contentment) is heard on violins. The theme has a long sweeping line over 12 bars. There is a sense of expansiveness, as the cellos add an ascending counter-melody. | IMU 2 - a forest scene
[“Theme” - indicated on the transcript] (music suggesting?) - a forest.
(what do you notice?) - a very shady forest like in the South West of Western Australia - a Kauri forest - tall trees.
Squirrels playing around my feet, hopping around and cracking nuts. |
| MMU 3 - a darkening, threatening mood
At section 103 there is a sudden darkening of mood - the horns and brass | IMU 3 - a brief storm
Like a storm coming, thunder in the distance. |
enter ff, and the strings play in tremolo. [Bonny engineered a cut from section 103 to 106].

**MMU 4 - the solo violin**
At section 106 the solo violin introduces a theme which depicts the Hero's companion (Strauss' description). It is chromatic, descending, and suggests a sadness or yearning. The horns support it with an even six quaver beat creating a feeling of security.

**MMU 5 - dialogue of the horn and violin** (the masculine and feminine)
At section 108 there is a dialogue between the 1st horn and the solo violin. These are the Hero’s love themes. The horn’s phrase ascends, while the solo violin answers with a downward turn. The horn repeats the ascending phrase, the solo violin answers with a downward turning phrase. There is a passing back and forth. At section 111 the solo violin has a longer phrase which ascends. The 1st horn joins in a downward moving phrase.

**MMU 6 - the horn and violin in contrary motion.**
The 1st horn and solo violin continue in contrary motion, the violin ascending higher and higher, the horn lower and lower. The orchestra enters with four strong chords, each dynamically louder, then dies down to piano.

**IMU 4 - support of the tree**
I am sheltering under a tall tree. (what does it feel like?) - supportive, leaning against the tree. I love trees. (what is the tree like?) - rough bark, very tall - I’m wondering if I can climb it - looking around the bottom of the tree.

**IMU 5 - playing with the squirrels**
(what do you notice?) - squirrels are still playing, three or four of them - looking at me wanting me to follow. I’m down on the ground with the squirrels, hopping away with them - they’ve stopped to play, throwing nuts.

**IMU 6. A hollow in the tree**
Walking off. I see a tree with a hollow in the trunk. Looking at the hollow.

client’s imagery sequence. The even beat of the kettle drum (MMU1) stimulates the client’s imagery of marching in an army (IMU 1). The expansiveness of the melody (MMU2) may have stimulated a sense of the trees in the client’s imagery being tall (IMU2). The darkening mood and tremolo of the strings (MMU3) evoke imagery of a storm (IMU 3). The composer’s description of the theme (MMU 4) being the Hero’s
companion, seems to be relayed to the client as she describes her love for the trees (IMU 4) and their support. At MMU 5 there is dialogue between the horn (the Hero) and the violin (his companion). The client’s imagery however is of squirrels playing at the base of the tree. What is described in the music is the dialogue between the Hero and his companion, whereas the client’s imagery is related more to a sense of play. Finally, the horn and violin (MMU6) move in contrary motion, one ascending the other descending. The client’s imagery (IMU6) is quite fascinating as she is drawn to a hollow in the tree. Not only does the sound of the music open out, with ascending and descending line, but a strong crescendo is followed by an immediate decrescendo, creating a rounded musical shape like a hollow.

In Table 2, the two client’s imagery bears some close similarities with the description of the music. Both clients identify immediately with the piano solo, and imagine themselves as the pianist. This is a clear example of transference to the music. Client #1 feels a partnership with the orchestra, and client #2 relates to the energy of the music. Both clients also relate to the contrast of the strings - client 1 comments how much she loves the strings, and client 2 responds to the change in the music as being gentle and embracing.

The two examples above show a close relationship between the descriptions of the music and the clients’ emerging imagery. Not all examples are this clear. Further examples are given in the larger study of pivotal moments in GIM (Grocke, 2000).

Table 2 outlines the descriptive analysis of the first selection of music on the Emotional Expression 1 program (Bonny, 1976). With this example I show two clients’ imagery experience with this music.

The two examples above show a close relationship between the descriptions of the music and the clients’ emerging imagery. Not all examples are this clear. Further examples are given in the larger study of pivotal moments in GIM (Grocke, 2000).

Table 2. Comparison of two clients’ imagery with Brahms Piano Concerto #2, 1st movement (the first selection on the Emotional Expression 1 program).

<table>
<thead>
<tr>
<th>Brahms: Piano Concerto #2, 1st movement, Allegro no troppo</th>
<th>Client #1</th>
<th>Client #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The concerto opens with the melody played by solo horn, mp.</td>
<td>IMU1-1: a strong disliked colour</td>
<td>IMU 1-2: an argument</td>
</tr>
<tr>
<td>The piano responds softly. The solo horn plays another phrase of the melody, the piano responds. At bar 7, the wws introduce the third phrase, joined by the strings, piano.</td>
<td>I’m in an orange dress, and I’ve always hated orange. (dress like?) - not flimsy, strong.</td>
<td>I’m remembering the argument this morning with T. (his wife). The argument is very different from the music. Music is about expression of passionate feelings and their resolutions.</td>
</tr>
</tbody>
</table>
MMU 2 - a building of intensity
The piano begins in earnest with a surging motif - an arpeggiated chord followed by two descending notes in octave, played staccato. The effect is one of moving then abruptly stopping. This motif continues in solo piano. At bar 23 there is a more lyrical part for the piano, which then builds in intensity.

IMU 2-1: playing the piano with orchestra
Always wanted to play the piano, so I’m sitting in an orange dress, belting out on the piano - I have the orchestra around me.

IMU2-2. A destructive passion.
I’m shouting.
Might be seen as destructive passion. Puts dampness on it. This is boom-boom music according to my wife.

(?what is it for you): Expressions of joy promulgating it.

MMU 3 - a triumphant march
At section A, the full orchestra enters with a re-statement of the first theme. This is a triumphant sound - the melody played forte, has a martial quality to it. The lower strings accompany playing marcato, so that there is a sense of a triumphant march.

IMU 3-1: in control
(“orch enters” marked on transcript) I’m in control, the orchestra will play with me - I’m listening to them, waiting for my time (what is it like to wait?) - good. I’m taking in their energy -

IMU 4 - Love of the strings
How much I love the strings - my head’s spinning with the sounds of the strings

IMU4-2: Gentle and uplifting
Becomes gentle and embracing.
I wish T. (wife) could enjoy this music with me. (Let her share it in imagination?). Like her to experience it as uplifting instead of noisy.

(You feel?)
Expressing energy I’d like to have. (Feel it within you?) Yes. It wants to have free expression.

MMU 4 - a quieter section
At 41, the strings carry a more lyrical section, a bridge section,quietening the dynamics.

IMU 6-1: a wonderful partnership
(“piano enters” written on transcript) A wonderful feeling of them and me, a real partnership.

IMU6-2: Liberating energy
(Energy feel?) Liberating.
(Feel about pianist?) He’s having a ball. Thinking about Moonlight Sonata - T. likes it (Part you’d like?) To be the pianist

MMU 5 - moving ahead
The second theme is introduced by the violins, with the lower strings providing a pizzicato bass. It has a sad quality to it, a yearning quality, building up. The effect is of moving ahead, well supported by the bass line. At B there is a sudden contrast of sound, the strings and wws carry a dotted rhythm, followed by fast descending scale passages.

MMU 6 - tension in the piano
At 68, the piano re-emerges, with the first theme, embellished by syncopated octaves. Piano part is played marcato - very strong. Piano and strings go back and forth Always a relentless tension in the piano part.
A Structural Analysis of the GIM Music

In my study of pivotal moments in GIM, I was also interested to compare the selections of music that underpinned the pivotal moment for four participants. I was interested to see if there were common elements in the selections of music that were playing at the time the clients experienced moments that were pivotal. I needed a structural model that was relevant to the music used in GIM programs - i.e. music of the Western classical tradition, recorded on CD. I developed a Structural Model of Musical Analysis (SMMA) to analyse these selections of music. The SMMA contains a comprehensive list of music elements, with sub-sections. Elements 1-12 relate to music form, while elements 13-15 relate to interpretations.

Table 3. A Structural Model for Music Analysis (SMMA) (Grocke, 1999)

1. **Style and Form**
   1.1. Period of composition: e.g., Baroque, Classical, Romantic; Impressionist; 20th century
   1.2. Form: e.g., Sonata form; ABA; Theme and variations; Rhapsodic form; Fugue; Tone Poem.

2. **Texture**
   2.1. Consistently thick/thin, or variable
   2.2. Monophonic; homophonic; polyphonic

3. **Time**
   3.1. Meter - 2/4 or 4/4; 3/4 or 5/4, etc.
   3.2. Complexity and variability in meter.
   3.3. Silences; rests; pauses

4. **Rhythmic features**
   4.1. Underlying pulse of the work - consistent/inconsistent
   4.2. Important rhythmic motifs
   4.3. Repetition in rhythmic motifs.
   4.4. Variability in rhythm - predictable/unpredictable
   4.5. Syncopation.

5. **Tempo**
   5.1. Fast; slow; moderato; allegro etc.
   5.2. Alterations in tempi: change of meter; use of accelerandi and ritardandi.

6. **Tonal features**
   6.1. Key in which the work is written
   6.2. Key structure; diatonic; modal.
   6.3. Major/minor alternations
   6.4. Chromaticism
   6.5. Modulation points

7. **Melody**
   7.1. The main themes in the selection (1st theme, 2nd theme with development or variations),
   7.2. Significant melodic fragments.
   7.3. The structure of the melody: propinquity; step-wise progressions; large intervalic leaps.
   7.4. Significant intervals (e.g., fall of an octave in a melody)
   7.5. Shape - rounded, ascending, descending.
   7.6. Length of phrases: symmetrical, short, long

8. **Embellishments, ornamentation and articulation**
   8.1. Embellishments to the melodic line
   8.2. Trills; appoggiaturas
   8.3. Accentuation: marcato; accents; detached bowing
   8.4. Pizzicato/Legato
   8.6. Use of mute

9. **Harmony**
   9.1. Predominantly consonant, or dissonant
   9.2. Consonance/dissonance alternation within the selection.
   9.3. Significant harmonic progressions
   9.4. Rich harmonies
   9.5. Predictable harmonies (e.g., I; IV; V progression)
   9.6. Unpredictable harmonies
   9.7. Cadence points - perfect; imperfect; interrupted.

10. **Timbre and quality of instrumentation**
A structural analysis of the music that underpinned pivotal moments in GIM

I used the SMMA in my analysis of the selections of music that underpinned four client’s pivotal experience in a GIM session. The four selections of music were:
- Beethoven: Violin concerto, slow movt
- Brahms: German Requiem, part 1
- Beethoven: Symphony #9, slow movt
- Bach-Stokowski: Fugue (from the Passacaglia and Fugue in c minor), orchestrated.

I listened to each piece of music and noted the features according to the SMMA descriptors. The following features were found to be common to all four selections:-

1. Each selection had a formal structure (e.g. theme and variations, ternary form or fugue) in which there was repetition of themes and of rhythmic motifs.
2. There was consistency in the rhythmic structure and pulse of all four works,
3. Rhythmic motifs were important in all four selections
4. The tempo of the four selections was consistently slow
5. In all four selections the tonal structure was diatonic, harmonic progressions were predictable, and harmonic structure was consonant.
6. The legato line was a consistent feature of all four selections, although pizzicato is evident in the accompaniment line, in three of the works.
7. In all selections dialogue between instruments was clearly evident.

The SMMA was found to be a useful tool to compare and contrast various selections of pre-composed music. Elements of the SMMA might be used in isolation for analysis of music in other music therapy.
methods— for example, in improvisation.

**Conclusion.**
The two methods of analysing music (descriptive and structural) provide different outcomes. In this study the music descriptions could be placed alongside the imagery descriptions (the GIM sessions transcript) to compare similarities in the flow of dynamics. The structural method of analysis was useful when comparing features of several selections of music to isolate specific elements common to all selections.

In GIM research music analyses are necessary so that we can better understand the role of music in evoking imagery experiences, moods and emotions. If music is the central field, as Goldberg suggests, then there is a great deal of research still to be done, to appreciate the unique experience of music offered in GIM.

**References:**


The “Universitat Ramon Llull” in Barcelona has started a new edition of a Postgraduate/Master’s Program in Music Therapy. This is a two-year program designed for people already holding a degree in music or a health/education-related profession that want to acquire the skills to become a professionally-qualified music therapist. The degree is awarded upon the completion of 600 hours with an acceptable grade average and successful completion of a final project.

The premise of this program is that every prospective music therapist should be committed to the subject of music and its therapeutic use with people. This should be evidenced by the academic and social behaviors of the prospective therapist in life, both in and out of the university environment.

**Entry Requirements**

- A degree (Diploma or Bachelor) in music or a health/education related profession.
- Music skills equivalent to three years of formal studies in a Music Conservatory or recognized music school
- English proficiency to the level of reading comprehension.

Personal qualities are also assessed through a personal interview.

For more information, please visit the university’s web site: [http://www.blanquerna.url.es/cat/ce/fpce/cepe00.htm](http://www.blanquerna.url.es/cat/ce/fpce/cepe00.htm)
Personal Qualities

For those who value knowledge, the learning process is continuous throughout life. To be an effective music therapist, one must develop:

- The ability to think, and therefore value and discriminate.
- The ability to feel, and therefore become sensitive to aesthetic qualities in music and life, and
- The courage to act, and therefore translate the abilities to think and feel into overt behaviors.

Successful music therapists demonstrate personal qualities of leadership, intellectual curiosity, social commitment, and emotional stability. They approach life, music, and the therapeutic profession in a positive, imaginative and enthusiastic way.

The music therapist tries to create a respect and desire for quality of life experiences, teaching others to learn and mature, react positively, listen responsively, and relate sensitively.

THE PROGRAM

Music therapists must be prepared and eager to assist those in need, from early childhood to the aged that suffer from:

- physical disabilities
- cognitive impairments
- social-emotional difficulties

In addition to personal competencies in music performance, improvisation, conducting, composing, arranging, repertoire, and other musical skills, they must be competent in the teaching of music at a variety of levels, and in the methods of music therapy in at least a few habilitative and rehabilitative settings.
In addition, there are four different tracks of 6 credits each that the students can choose from as an area of specialty:

- Medical Music Therapy
- Music Therapy in Education
- Psychiatric Music Therapy
- Geriatric Music Therapy
This coursework is designed to give students the ability to apply theory and research to practice, and an understanding of legal and ethical issues that will have an implication in the practice and research in music therapy in each of the fields. The students will also have the opportunity to hear a variety of theoretical orientations presented by different professional music therapists from the international arena, who will share their area of expertise for each of the tracks.

Clinical Practicum Sites
Clinical field experiences are an integral part of the music therapy curriculum. Local agencies and the Centre Clinic de Musicoteràpia [http://www.musicoterapia-ccmt.com/](http://www.musicoterapia-ccmt.com/) are affiliated with the “Universitat Ramon Llull” and provide a wide range of clinical practicum options for students in the program.
Welcome to a new issue of Music Therapy Today! I am taking my duties of being the new editor of this Online-Journal, it is 11.30 A.M CET and I am awake now ;-) to introduce you to this new issue, which is thematically wrapped around supervision and improvisation in some of their different shades.

In Germany the beginnings of a ‘stand-alone’ professional music therapy education started back in 1978 with the so called "Mentorenkurs" (a teacher course of music therapists) which took place at Herdecke hospital. Those days the two main streams of "Music as Therapy" (Art Therapy orientation) and "Music in therapy" (psychotherapy orientation) as Ken Bruscia differentiated in his 1987 book, swept into several institutions of practice and teaching. For a short period of time the two main streams seemed to be in opposite to each other, culminating in discussions about the 'right way' of doing 'real' music therapy. There were seemingly contradictory ideas about how the psychotherapeutic origin of supervision should be seized into the practice of music therapy and used in the practice of education.

This old dichotomising debate seems to be over now, hopefully. Music therapy has become a scientific and therapeutic discipline of its own and students decide what they want to learn. This means, like in philosophy, an informed student can decide to choose a certain university to learn and hear what the phenomenologist think and say or what existentialists, rationalists, pragmatists, etc. are teaching. This is where we are in music therapy now. This is a healthy
development. It was the main tune at the World Conference 1999 in Washington: "Many voices, one song".

Nevertheless, the field of supervision in music therapy needs to be continuously reflected in a social learning process. As things in the world change more rapidly, so do ideas on supervision in a certain practice field.

Harlene Anderson focuses on “Supervision as a collaborative learning community”. Music therapy is about relation, therefore everyone in this practice is an expert on this processes. Collaborating, constructing and connecting between therapists create a community, which grows into their own socially constructed, situated form of supervising each other. David Aldridge saw her work while collecting material about supervision and asked her to collaborate in the interest of transdisciplinarity.

David Aldridge in his article on “Research supervision: Developing a community of enquiry” reminds us that there is still no training base for research supervisors. As the field of music therapy emerges into the future, research has become a vital part of its development. But as it is usual in any other scientific fields, there are certain common rules of scientific rigour that have to be accepted and regarded as a tradition in an ecology of ideas, before stating a new brand of scientific ideas. Research is a process and – for instance in a doctoral thesis - this process has to be supervised by a personal mentor who knows about traditions and pitfalls of the certain field. On the other hand every experienced researcher looks on developments from its own his-story/her-story. So a community of enquiry is needed to counterbalance between the overwhelming traditions and the current stream of thoughts.

Paxti del Campo provides us with his insights into relationship processes in improvisation. Creative psyche and music therapy discusses relationship in
improvisation as a “transitional area where the patient’s and music therapist’s improvisations interact in continuous instability, where sound and silence create a dialogue and listening”. Music therapy is a creative space which is therapeutically used and reflects the ongoing processes of daily life, where humans come into being by acting and performing with their situational abilities to improvise over the themes that need to be solved. “There are no problems only solutions” as John Lennon stated in one of his songs. Improvisation is an ability, which becomes even a concept in organisational psychology to define how members of organisations create their solutions.

Last article in this coda comes from Carl Bergstrom Nielsen and it is an extended version of his introduction into a book on improvisation “Vermittlungen ... musically speaking”, which he has edited together with Eckhard Weymann. In this book and his introduction we can read about how our profession is reflecting on this valuable tool of clinical practice and how it is taught to our students. Trygve Aasgaard has already done a review on this book in the Nordic Journal of Music Therapy. Annemiek Vink, our Book Review Editor, is working on another review for Musictherapyworld.net, which will be published in our next issue. Please, send your newest books for review.

To stay in touch about what is happening on our website and some parts of the music therapy world sign in for our Newsletter.

Sorry for that much letter-bombing in my first editorial for Music Therapy Today, the magazine for music addicts. I hope, I have not bored too much with my way of writing about what I think, but I’d be happy to discuss as we are going further on our ways to sing our song with different voices.
To whom it may concern I wish some happy summer days,

Until we read again

Joerg Fachner
Abstract
There is a need to define the relationship between creativity and psyche in improvisation in music therapy. By means of musical improvisation, we create a transitional area where the patient’s and music therapist’s improvisations interact in continuous instability, where sound and silence create a dialogue and listening.

The thoughts I am going to describe are based on the need to define the relationship between creativity and psyche as part of improvisation work in music therapy.

Every day it becomes more and more necessary to more explicitly use the process of artistic creation as a therapeutic framework. In this sense, I will use as a basis the work of Dr. Héctor Fiorini, a doctor of psychoanalysis and a professor of the School of Psychology at the University of Buenos Aires, who defines this relationship within a new system of psyche, i.e., Creative Psyche.

According to Fiorini “The process is something that is created ... For creation to exist, there must be a series of instruments that establish a creative field. A creative field is a space with multiple possibilities. Nothing is sure, we only establish spaces of possible events.”

Through improvisation and creation, music therapy makes it possible for these spaces of possible events to exist in a direct and enriching manner. We must investigate the use of improvisation and creation processes within parameters that allow us to know not only the meaning of the product, but also the changes that the patient brings about during the process. In this way, we will be able to intervene more precisely as containers and enablers of new relationships and communications networks.

In music therapy work, music is a transitional object that provides a vehicle and a metaphor for creative psychic dynamics. By means of
musical improvisation, we create an transitional area where the patient’s and music therapist’s improvisations interact in continuous instability, where sound and silence create a dialogue and listening.

The idea is to offer a linking space where creativity oscillates between the polarity of repetitive fixation and the polarity of continuous innovation, recovering the history of self-creation that had been blocked and arrested.

“(…) in the clinic we have been called to create. … when individuals, groups or communities consult us, they do not only do so to be told what happens, but so that we can contribute to creating something different with what happens. In this manner, the clinic also turns into a creative space.” Fiorini

In order to approach the concept of creativity, we must observe and take as a reference various ideas from different fields and search for a common path in all of them that will lead us to the understanding of psyche through creativity.

Creativity and significant living

“When creative experience is lost, the feeling of a real and significant life disappears” Winnicott.

We must begin by understanding creativity as the enabler of human processes and not only as an aspect concerning the world of art. Creativity appears to us in everyday life through experiences where trial and error, potential and limit, the possible and the impossible, security and insecurity, sound and silence, and many others, live together in processes that are in constant movement.

This creative process is present in significant living when the adaptation to reality is active and not passive. The concept of active adaptation – according to Pichón Rivière – “is a dialectic concept in the sense that, as soon as the subject is transformed, he modifies the medium, and when modifying the medium he modifies himself”. From this point of view, the human being can feel that he is an active part of the events he is living, in a certain manner “the master of his own life”.

In the words of the artist Jorge Oteiza:

“Art does not transform anything, it does not change the world, it does not change reality. What really transforms man in his evolution and completes his languages is he himself. And it is this man, transformed by art, who can try to transform reality through life”.

In view of these two thoughts by Rivière and Oteiza, concepts come together, such as self-knowledge, conscience, listening attitude and active adaptation, concepts that shape significant living or creative living.

But, what is creativity? According to De la Torre (1985) “Creativity is above all a polysemic, multidimensional phenomenon with a plurality of meanings”.

Omnipresent, called upon by artistic, scientific and business environments, it resists the restriction of precise definitions, because, as Torrance (1988/1993) points out, “it is almost infinite; it commits every sense ... Much of it is invisible, non-verbal and unconscious. Therefore, even if we had an exact concept of creativity, I am sure we would find it difficult to express it in words.”

However, if we are going to study it, we must have some approximate definition, some of which are:

Ribot (1900), Dugas (1903), Queyrat (1905; 1908) or Ruyra (1938) are conscious that creative imagination or creativity is not exclusive to geniuses or to exceptionally talented people. It exists in everyone although with different levels of intensity and application. “The human spirit – as Dugas wrote in 1903 – has, from its origins, the need to invent, and this need is never discarded”. With regard to ideas of inheriting genius, these authors already proclaim the universality of creativity and the possibility of stimulating inventiveness.

In 1950, Guilford gave a speech of far-reaching importance to an assembly of the American Psychological Association to identify and develop creativity, which was considered “the creativity manifest,” dividing its history into a “Before” and “After” period. This author’s approach leads to overcoming behaviourism, the idea of genius and the monolithic conception of intelligence favouring a factorial conception of creativity.

For behaviourists, there would be no need to study or explain creativity because creativity, understood as a specific process that intervenes in producing something really new, does not exist. Either the product is really something old, or, if it is new, it came about by accident.

For the Gestalt theory, creativity refers to the fact that different specific elements can give rise to different entities due to the form in which they are arranged. It insists that the whole is different than the sum of the parts, and creativity would consist of the ability to break with the tendency to give a common answer, which involves a new way of perceiving the characteristics of objects.

For the latter, creativity begins with a problematic situation, with the perception of something unfinished, with the attempt to organise the structures observed in a significant whole.

Wertheimer stated that a strong dependence on specific prior experiences could produce “fixations” on a certain problem-solving tactic, interfering with and hindering creative thought processes. In order to break with prior experience and produce truly original solutions, it is necessary to analyse the specific difficulties of the problem at hand; if one manages to “mentally fill” the gaps of the problem, the solution would fit by itself.
In his 1950 theory, Guilford distinguishes between the following characteristics of creativity:

1. **Sensitivity to problems,** it appears that creative people are especially sensitive the existence of problems. This quality has many forms: being aware of the need for change, of applying new methods, of defects and deficiencies of things.

2. **Fluency of thought,** at this moment in time Guilford considers it a heterogeneous factor, and he will later make a factorial distinction among four different types of fluency: verbal, associative, expressive and of ideas.

3. **Originality,** as the concept most commonly associated with creativity.

4. **Flexibility of thought,** as the ability to abandon old ways of treating problems and give thoughts a new direction.

5. **Redefinition,** as a common aptitude of creative thought favouring problem solving: the revision of the form in which an object or concept is used.

6. **Evaluation,** with a decisive role in the final result of the process. The product is evaluated by its author according to the prevailing criteria for mastering the experience where it appeared.

The aptitudes that are most important for this author in relation to creative thought could be divided into two categories:

1) **Divergent production aptitudes.**

2) **Transformation aptitudes.**

From De Bono’s point of view, the objective of lateral thought would be the change of model, the breakdown of its structures so that the different parts of these models could be arranged differently.

According to this author, “the mind is characterised by the creation of fixed concept models, which limits the possibility of using the new information available, unless there is some means of restructuring the already existing models to objectively update them with the new data. Traditional thought allows models to be defined and their validity to be checked, but in order to achieve optimum use of the new information, we must create new models to escape from the monopolising influence of those already in existence. The function of logical thought is to initiate and develop concept models. The function of lateral thought is to restructure these models (perspicacity) and create other new ones (creativity). Logical thought and lateral thought are complementary. Ability is required for both” (De Bono, 1970/1998,)

Freud (1958) gave an explanation for the role of conscious and unconscious processes in creativity and suggested that creative attempts or efforts can be seen as wishes being carried out. In general terms, as Arieti (1976/1993,) pointed out, “although he contradicted himself very often in this sense, he saw a great similarity between
neurosis and creativity: both have their origin in conflicts arising from the most fundamental biological impulses. In other words, they are attempts at resolving conflicts originating in powerful human instincts”.

According to Jung, 1969, the greatness of creative work comes from the reactivation of the archetype, and the creative process consists of an unconscious animation of these fundamental experiences that occurred on repeated occasions over generations and remain in the collective unconscious. When the wealth of dominant experiences in the collective unconscious awakens, the creative process confers the work of art with universal meaning.

More recent psychoanalytical perspectives have continued to make the creative process depend on those preconscious functions that swing precariously between the rigidity of the conscious function on the one hand (anchored in reality) and the rigidity of the unconscious function (anchored in stereotyped, repetitive symbolism of unconscious processes) on the other.

In 1930, Vygotski explained his conception of imagination and creativity in childhood, differentiating between reproductive activity and memory (which emerges from recall) and combining or creative activity. In view of this differentiation, he considers creative activity any human activity whose result is not the reproduction of what happened in one’s experience, but the creation of new forms or activities.

For Vygotski, imagination, fantasy and creativity are more conscious than unconscious processes, though full of emotions. He linked creativity with fantasy, explaining how subjective thoughts are directed towards reality and are combined with realistic thoughts.

The humanist school understands creativity in terms of personal fulfilment, and considers that the tendency of the human being towards self-fulfilment is the greatest source of creativity.

For Maslow, someone with creative self-fulfilment has a relationship with the world characterised by:

a) open perception, shying away from prior categorising or preconceived notions;
b) spontaneous expressiveness, lacking inhibition;
c) a great attraction to the unknown, to meditate about things in depth, avoiding comfortable stances;
d) the integration of aspects commonly considered irreconcilable (egoism – altruism, individualism – concern about social problems, childishness – maturity, etc.);
e) as a consequence of this integration, self-acceptance takes place; such people have resolved fundamental conflicts and show greater security and confidence in the activities themselves.
Rogers (1978, 1980) defines creativity as the appearance of a new relationship product which comes from the uniqueness of the individual on the one hand and the circumstances of life and the contributions of other individuals on the other.

For this focus, one of the characteristics of the creative individual would be an openness of experience. Products must be novel and emerge from a process where interaction between the creator and the materials occurs by force.

Sternberg and Lubart establish that intelligence has three key roles in creativity: a synthetic role, an analytical role and, finally, a practical role:

a) the synthetic or formative aspect consists of the ability to see things in a new light or not in a set way, “redefining problems and putting things right”;
b) the analytical role of intelligence consists of “assigning resources and evaluating ideas”, that is, recognising which of the new ideas are also good ideas, in the sense that they allow the effective allocation of resources and will finally be widely valued;
c) the practical aspect, understood as the ability to promote an idea and appropriately present it to the public.

On the other hand, a creative person tends to show a particular set of personality qualities. After reviewing these attributes, there are five characteristic qualities that stand out:

a) tolerance of ambiguity,
b) willingness to overcome obstacles and persevere,
c) willingness to grow and openness to new experiences,
d) willingness to take risks,
e) individualism and support of one’s own convictions

As a conclusion from the different concepts of creativity and according to De la Torre (1991a), it is possible to point out some constants that allow the establishment of a conceptual framework outlining what we understand as creativity. According to this author, creativity:

a) is an intrinsically human potential; it is defined as an ability, as a potential and not current quality, specific to the human being;
b) it is intentional, directional; it aims to respond to something, to satisfy an internal tension or a tension from the medium;
c) has a transforming nature; the creative individual recreates, changes, reorganises, redefines the medium via dialectic and transforming interaction with it;
d) it is communicative by nature; it is orientated to the other and turns into a message when communicating via a certain symbolic system;
e) it means novelty, originality; these were the most universally shared attributes from the first studies on the subject and formed the most outstanding identifying factor.
Creating and Growing

“(…) creating means bringing about tensions and contradictions and giving these tensions and contradictions new forms so that these forms can contain them and make them fertile. (…) The creative worker takes the terms of a contradiction, brings them together, works inside the contradiction and establishes relationships there. (…) this work is the work of the clinic (…) to help the contradiction turn into material, material from which to build” Fiorini.

If we offer different people the chance to play with the two words Create and Grow, we get associations that envelop these tensions and contradictions. Words such as: Restlessness, bearing fruit, risk, evolution, impossible, difficult, positive, art, need, getting involved, time, movement, process, etc. These words in relation to each other favour creative and divergent compositions, such as:

Growing is an evolution in the course of time which implies movement in which a difficult and positive, high-risk transformation takes place; and through a fruitful change, we make art to create you.

You evolve and change you take a risk.
It is not easy, but it is positive.
Time is process and movement which will bear fruit in you, to be sure, the seed of art.

In these examples the words Create and Grow are called upon to create a space between them where urgency and time, movement and stillness, separation and union, etc. create structures where multiple contradictions are woven together and resonate. Winnicot called this field between elements transitional space, the space of transitional phenomena where creative processes emerge. The newly created field will be an open display space for a wide variety of relationships and possibilities, for limitless reverberations, constructing an architecture in its core that links multiple oppositions-contradictions.

“For the human being, creativity means to go beyond what is known, to reach the truth (something lived at the moment that expresses our individual connection with the whole) of things. And that is where chaos appears”. (Briggs and David Peat 1999).

Improvisations in music therapy must not be subject to linear, Cartesian action; on the contrary, they must be open to the laws of chaos and the laws of change. It is the music therapist’s task to stimulate the transition from chaos (understood as disorder without meaning) to the perception of reality made evident in all of its contradictions, not exempt from harmonious order.

This complexity requires noting the evident contrasts and shades of an
improvisation, and also the small variations that are established and the possibilities arising between them.

The evolution in the improvisations will be found when they are reorganised in a different way, with varying degrees of freedom and including a new key and a new tempo, promoting new structures of self-organisation.

Fiorini invites us to view the materials of the therapeutic process as sets consisting of:

These materials, which are ways of being and presenting psychic-related things, and which happen wrapped up and crossed by UNIVERSES OF SOUND, produce different combinations, forming living blocks which breathe:

INTENSITIES
SPEEDS
RHYTHMS

CONFIGURATIONS

SEQUENCES

DESIGNS

STYLES

FLOWS OF ENERGY

COMPOSITIONS OF FORCES

VARYING FORMATIONS

DIFFERENT CODES

These materials are always individual, specific to each subject, each group and each moment of space and time. They are happenings, events never to be repeated identically and generally, in which senses occur as well as signs that cannot be made semiotic, that cannot be put into words or speech as they are pure presentation.

“Truth and chaos are linked. Living with creative doubts means entering chaos to discover that truth cannot be measured in words” (Briggs and Peat).

Creativity appears in improvisation when we facilitate a space of chaos and contradiction where an interchange of sensations and perceptions occurs making a new communication code possible. This leads us from the known as reassuring space full of seductive possibilities to the real impulses of doubts and uncertainties capable of organising themselves into creative chaos.

Within musical improvisation, we find a continuous flow of forces that virtually trace an infinity of possibilities and bridges lasting for a moment.

Prigogine reminds us that previously we identified science with precision. Now we require sciences of the imprecise, of the incomplete, in order to approach the chaos of the infinite and dare to navigate it.

In order to carry out an improvisation based on the theory of chaos we
can find help by following in the steps of Briggs and David Peat who suggest the creation of three vortices, which are understood to be “an individual, differentiated entity, however, inseparable from the river which created it.” A musical improvisation or creation is created by the patient, it is his own, but at the same time it reveals truths related to the world surrounding him.

Creation of vortex 1: Turbulence: the space where contradiction becomes conscious and order turns into chaos. Where we sacrifice what is familiar to enter chaotic material enveloped in the unconscious.

Creation of vortex 2, Branching and expanding: The ability to take advantage of errors as an opportunity for change. Making use of a sound, a rhythm engendering a seed that will bear its fruit with expansion.

Creation of vortex 3, The open flow: Where the here and now allows time to vanish as something linear and convert an improvisation or creation into an open work which we can enter and leave creating a constant flow between the old and the new.

Each improvisation creates another history on our own history. As Miguel de Unamuno said, “The future gives new meaning to the past”.

Each improvisation or creation turns into a new possibility. We must fence in each of them, establish limits so that links and bridges are set up between them, thus multiplying the possibilities of new realities.

This is how we will turn the therapeutic space into the space where different stretches of the patients’ life are represented, where the space of contradiction is transformed into the field of possibilities having recourse to silence as the point of departure for dialogue.

The dialogue of the impossible to find the possible

In reviewing the existentialist philosophers, Heidegger and Sartre, we find that “(...) the concepts of project, vital project, must have a significant place in our comprehension of the facts in the clinic. In these authors, the thought of the possible emerges as the horizon of existence, a concept which in our opinion indicates an entire space of psyche, a space around which the creation as a project is arranged.” Fiorini

In order to understand the model contained in this proposal, Fiorini establishes a topic where he places the operations of the creative
process and makes room for the anxieties and failures of these processes.

The **given** is what is constituted, known and established. It is the point of departure for creative processes. From there springs the impulse to cross the limit, rearranging known forms. **The impossible** corresponds to the conflictive space where forms and movable matters live together in intense acceleration (see Table One).

**The possible** is where a new area of reality is created. Where a new object takes form and the creator puts distance between it and himself.

The project, **vital project**, is found in the three spaces of the topic:

In the given as the potential (the same problem holds the seed of its keys and solutions)

In the impossible as the transformation test space, the sign of possibilities.

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<thead>
<tr>
<th>The given</th>
<th>The impossible</th>
<th>The possible</th>
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<tbody>
<tr>
<td>Place of conflict</td>
<td>Transformation space</td>
<td>New production of relationships between opposites</td>
</tr>
<tr>
<td>Blockage because of excluding oppositions</td>
<td>Setting up a “productive crisis” (creative field)</td>
<td>Space transformed by the creation of a new personal reality.</td>
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<tr>
<td>Departure situation</td>
<td>Place of vertigo</td>
<td>Updating the potential</td>
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<tr>
<td>Stagnated form (Blockage) of the binary confrontation</td>
<td>Search for keys to the potential</td>
<td>Transformed place where the project is to be sent</td>
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<tr>
<td>Place where the crisis is suffered.</td>
<td>Process of change</td>
<td>Place where the contradictions and opposite sides of a conflict are harmonised (integration without loss of identity)</td>
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<td></td>
<td>Contradictory space</td>
<td>A new view of reality and oneself</td>
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<td>Individual conflict resolution by creating a way of relating binary terms</td>
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Table One: Fiorini’s concept of the impossible, possible and the given.
Music Therapy Today (online), June, available at [http://musictherapyworld.net](http://musictherapyworld.net)

In the possible to update new forms, then to launch them for new acquisitions and ends that will once again, perhaps, turn into the beginning of other changes.

Fiorini’s proposal makes it possible to see human growth in relation to the ability of the person to oscillate through the spiral of The Given, The Impossible and The Possible.

As Fiorini points out “falling into the impossible is a risk of this mobilisation, of this provocation of chaos”, but even so, chaos opens the possibility of building new objects, new forms and relationships, that is, building the possible as the alternative to the real, and letting a new reality appear in this place of the possible.

The creative pulse is incessant and therefore a new object transformed into the “possible” will become part of the given to once again enter creative processes.

The music therapist works in this space of possible events and possibilities, walking through processes that are being built over and over again, where nothing has a fixed place; the patient and the music therapist travel along the routes the process takes.

Seeing improvisation as a creative field where a multidimensional network of forces and energies is traced, where the patient builds – destroys, moves among his own contradictions, makes it possible to convert improvisation not only into a product, but also into a process where sound envelopment is being recreated and multiplies itself into new realities in constant change.


GRISONI, D. Compiler: *Politics of Philosophy –Mexico, Fund of Economic Culture*


Introducing “Vermittlungen – musically speaking”
Carl Bergstrøm-Nielsen

Abstract
The book Vermittlungen – musically speaking deals with various aspects of improvised music and improvisation teaching within music therapy training. Here below is the introduction (English version) which has quotations from all the authors. The book is bilingual, and it was published both as a special issue of Einblicke, December 2001, and on the internet: http://hjem.get2net.dk/intuitive/vermittlungen The German version of the introduction can also be found behind this link, together with all the other contents. The publishers, Carl Bergstroem-Nielsen (Aalborg University, Denmark) and Eckhard Weymann (HfM, Hamburg) hope it will stimulate interest for dealing with the medium of improvised music itself, and they welcome email reactions to the authors to this end (please see inside the link). Background of the articles was the Hamburg Symposium in 1998. In 2003 or later, a second symposium is planned to take place.

During the last decades, musical improvisation as a method in music therapy has acquired a central significance, both regarding its method and theory. Within various concepts of therapeutic treatment, improvised playing (in the form of playing together of therapist and patient, of the patient playing in the therapist's presence, of the therapist playing for the patient) is considered important, although with differing reasons and in different contexts of actions and treatment. The importance of improvisation in music therapy, especially within active music therapy, is also reflected in the curricula of music therapy educations in which the subject of "improvisation" is represented everywhere. However, in professional circles there has till now only been a little discussion of what lies behind this in each single case, which goals of learning and which theoretical concepts as well as those of method and didactics are pursued, which psychological and practise-oriented concepts, which concept of music and which philosophical and aesthetic reflections form the background of improvisation teaching.

In September 1998 in the rooms of the Musikhochschule, a symposium took place in Hamburg which was for the first time devoted to the theme of improvisation teaching within music therapy training. The program committee was: CARL BERGSTRØM-NIELSEN, HANS-HELMUT DECKER-VOIGT, FRITZ HEGI, ECKHARD WEYMANN. Following an invitation from the Institute for Music Therapy at the Hochschule für Musik und Theater and from the Institute for Music Therapy and Morphology, 45 colleagues from eleven European countries met (teachers, researchers, directors of study) in order to exchange thoughts on this
theme for the first time. The results of this congress are documented here. The present articles have mostly arisen from the lecture manuscripts written for the symposium, supplemented by thoughts which were born out of the dialogues during the symposium and after.

**Fitzthum:**
On one hand, the student is supposed to be able to translate everything (images, landscapes, emotions, stories...) into music. On the other hand, it is repeatedly said to her that "solely" the therapeutic relationship is the healing factor.

**Metzner:**
Improvisation instruction... must be tailored to the respective music therapeutic model on which training is based. This applies...also to the underlying definition of music. In slightly exaggerated terms, instruction in improvisation that is based upon a psychoanalytic concept cannot be limited to rhythm exercises or the improvisation of a blues theme. Rather, the trainee must learn to deal with emerging material...Accepting the repulsive, the broken, the never-ending, or the extreme is a part of it.

Unfortunately, what cannot be adequately rendered in the text version of a congress is the way it is alive to participants. Concerts with improvised music contributed also especially to that and should at least be mentioned. As a prelude, GRUPPE TONFALL (BARBARA DEHM-GAUWERKY, JUTTA HOPPE, ALMUT KOCHAN, SUSANNE METZNER) played a concert under the heading "to re=peat the difference" [untranslatable play of words, meaning also "to re-cover" in German]. This heading is programmatic because it is contradictory and ambiguous. On the second day, the group ILLUSTRIO (FRITZ HEGI, PIT GUTMANN, TOMI HIRT) did an "improvised dialogue lecture + concert" with the title "Improvisation between art and therapy". Five "triagrammes" which were presented on overheads served as starting-points for the trio to discuss and circumscribe them in both musically-scenic and verbal-conceptual ways. THOMAS KEEMS gave a stimulating concert performance under the heading "Time - Spirit - Rhythm" with verbal introductions to the pieces.

In several contributions, authors reflect on the specific context belonging to the improvisation teaching of a higher education, on its relation to other subjects regarding the curriculum and on the concept of therapy which is brought forward in each case, and the possibilities and difficulties of this context is presented. Especially, the precarious relation between musical-artistic and psychological contents of the curriculum are debated. These two kinds of content meet each other and overlap, although they sometimes also inhibit each other (see among other contributions those of WEYMANN, METZNER and FITZTHUM).

Admittedly, those practical abilities and skills that are required when dealing with musical instruments represent an important side of playing ability. However, the psychic backgrounds are equally important in order to improvise, and here the realm of self-experience and learning therapy are touched upon - which for the student is usually connected to very individual and fundamental learning experiences.

**Keemss+Buchaupt:**
The division of the training programme into two main areas, improvisation seen from its musical aspect and therapeutic improvisation, strongly presupposes that one knows about both areas and about the details of the programme. This allows
Bergstrøm Nielsen, C: Introducing "Vermittlungen - Musically speaking" Music Therapy Today, (online), June, available at \url{http://musictherapyworld.net}

...for concentration during teaching on one of the main aspects, on the other hand it refers music to its possibility of acquiring a therapeutic function within the therapeutic relationship as well as also therapy is referred to the phenomenological depth dimension of music.

Vieth-Fleischhauer:
To connect the "art of improvisation" with therapeutic know-how as practise demands it from us, seems to me an easier task when those who are to become music therapists during their education experience these two cornerstones of their work not as two areas separate from each other, but as intimately connected to each other.

Deuter:
Problematic practises in the method of living (by avoiding, identifying or denial of opposite tendencies in question) have a parallel in the way in which the patient treats the musical material. Therapeutic endeavour can (with this understanding of the concepts) be viewed as the attempt to arrive at polarity where there is opposition.

For WEYMANN, improvisation teaching offers the possibility of training the ability of transfer which is so fundamental to therapeutic work, of translating and verbally reflecting mental circumstances such as they appear in musical figures in addition to the promotion of playing techniques and of creative-intuitive abilities (see also GROOTAERS). Two exercises he uses in this teaching, "Casual playing" and "Melody from a single note" are presented as examples. With these exercises, skills in letting go in terms of a freely floating attention as well as the concentration on one idea are trained - these have to do both with playing technique as also with a self-experience of the musician's personality. In addition, he discusses the relations between recent music history and improvisation practise such as it has come into being in music therapy.

Weymann:
My thesis is this: cultural practice, as unconscious and unknown it may be to the individual patient, serves as a hotbed for that which might be expressed within the refuge of therapy... we could ask ourselves what it means for music therapy...when therapeutic playing practice is not covered any more by cultural forms? Do we then have to expect a gradual shifting of emphasis of the methodology of music therapy as well - for instance towards a more intensified application of receptive procedures?

Stige:
Picasso's art is not a unique example, and could not be understood through psychological and diagnostic concepts. The diverse art of the 20th century has made it extremely clear that art might be related to many and very different sets of values. Wholeness and completion could hardly be said to be universal or general values, many works of arts cultivate fragmentation, they are open-ended.

Somewhat differently, SUSANNE METZNER seizes the same theme: the differentiation (and connection) between contents of the curriculum dealing with aspects of art and craft and those contents dealing with psychology, as she writes about the interaction between music therapeutic self experience and improvisational playing practise. Musical playing practise is affected and influenced by desires, anxieties and inner conflicts. In order to deal adequately with these processes she proposes some ethic rules of the game in order to secure a separation of improvisation training.
from music therapeutic self experience for the students. While the importance of self experience has long been known and the psychological basis of music therapy has been well worked out, she now argues that also standards of improvisation teaching should be discussed in more detail. She states some goals of her own improvisation teaching as paradigms.

The subject of therapeutic improvisation is also viewed by ELENA FITZTHUM as the central meeting-place in the music therapy curriculum, as the basis of professional identity which is to be developed by students. Music therapy techniques (here, especially improvisation techniques) as reflected on by FITZTHUM, should become a link between musical craft and therapeutic relation. Some established forms of improvisation in the training ("Tuning in" and "Musical dialogue") are presented in greater detail and discussed.

At this point we we have again touched upon the basic question about the music concept of music therapy, like several times before in this text. As what should we view improvisations in music therapy? This is where authors take different directions, even within "the" very discipline of music therapy. But ROSEMARIE TÜPKER is dealing with differences on a much larger scale between attitudes of music therapists and attitudes of academic musicology (applied to German language area). On the background of this difference it seems possible to distinguish an indigenous music concept within music therapy which transcends internal polemic attitudes (admittedly, it still has to be worked out) "which could also inspire other realms of music life and could give new impulses to musicology as well as to music education..." (p.#) (Cf. the thoughts of STIGE in this volume!)

It is often the case that authors within the professional music therapy context, in order to propose a marked standpoint in the discussion (which could be a psychological or an artistic-aesthetic one), are willing to accept being one-sided. MARTIN DEUTER shows a possibility to mediate between such standpoints in a model of polar tendencies of effect in the psycho-aesthetic "material" of improvisation. Differentiated possibilities of terminology and evaluation result which can be useful both in a didactic context and in music therapeutic practise.

The specific properties of the medium of music, its possibilities and determining factors and the search for suitable forms of students' personal relating to music is also discussed in the contributions from BERGSTRØM-NIELSEN, and KEEMSS / BUCHHAUPT.

When confronted with the variety of idioms as it is characteristic of contemporary music life, one might as a student think it would be impossible to acquire even an approximate musical equipment during the study. As a way out of this dilemma, BERGSTRØM-NIELSEN proposes a pluralistic "meta-stylistic view ... on the basis of experimental music aesthetics". In order to develop this view, he especially makes use of a concept of musical parameters drawing on compositional thinking and theories dealing with new and experimental music. In addition to presenting his Parameter-Exercises for improvisation training he states a clinical example.

In their contribution, KEEMSS and BUCHHAUPT present the contents of the curriculum at the Fachhochschule...
Heidelberg in an elaborate form serving as the background of improvisation teaching: although there is a division between an instrumentally orientated playing practise and music therapy practising, there are many interconnections, for example in the subjects of phenomenology and sociology of music, listening practise and musical analysis.

STIGE demonstrates the significance of aesthetic theories for music therapy. Starting from the statement of KEN AIGEN saying that music is a medium and not just a means he investigates the problem arising from transferring classical aesthetic values like "wholeness" and "good figure" to contemporary forms of expression and especially to the music of music therapy which clearly also has to do with fragmentation and ugliness. Philosophical concepts like "polyphonic dialogue" from BHAKTIN and "aesthetic practise" of the late WITTGENSTEIN can be useful here.

**Bergstrøm-Nielsen:**
There is an important patchwork aspect to music just like to language which is always in the process of borrowing elements and processing them and passing them on again. ... And music aesthetics and collage works of composers like Charles Ives, John Cage, Karlheinz Stockhausen and others take this into account...
Taking in the pluralistic aspect of experimental music aesthetics, I find it yields a credible solution to the problem of relativity.

**Tüpker:**
On the background of music therapy and improvisation as a direct form of musical communication, one could set up a concept which understands music as a means to self-cultivation and to the cultivation of our relations.

**Grootaers:**
All supervisees account of different problems connected to the interpretation of musical productions in music therapy. The common question in all these problems can be formulated thus: "how can I trans-late from musical occurrences into their verbally captured meaning in order to achieve a therapeutic goal".

FRANK G. GROOTAERS focuses his contribution on the explicitly psychologically formulated issue about the meaning of improvised music, about its interpretation. He proposes a specific hermeneutic questioning technique for verbal interpretation and "translation" of improvisations in a form suitable both for working with students and with patients.
He demonstrates the different lines of thinking (connected to a variation of perspective) pursued by this method through a case vignette from a music therapy.

Also the contribution by HANNAH VIETH-FLEISCHHAUER deals with the issues of what is brought forward in improvisations and what is the outcome of improvisation in therapeutic processes. Using an example from a training seminar she shows the steps and dimensions of a hermeneutic interpretation process in which the meaning of the playing when talking together afterwards is gradually revealed. She points out the multitude of possible connections and explains how she deals with them methodically.

We hope that through publishing of these articles the discussion which first took place among experts at the symposium can now be broadened and that new interested colleagues will take the
opportunity of taking part in it. This can be made possible, practically, by taking contact to the authors in person, by letter or by e-mail. (Please use the formula at the website to send emails and we will forward - this was necessary because of spam problems on the internet.)

And to conclude with, some words of thanks. The Andreas-Tobias-Kind Foundation in Hamburg made the editorial work with this documentation possible through a generous contribution. The University of Aalborg contributed to cover production costs of this "European" edition. We would like to offer our warm thanks to both institutions! We are also very thankful to the chair of BVM, the German Association of Professional Music Therapists (especially SUSANNE METZNER) and the editors of "Einblicke" (HANNA SCHIRMER) for having the courage to take the publisher's risk for this collection of articles, which is indeed specialised - and even bilingual!

Humlebæk / Hamburg June 2001
Carl Bergstrøm-Nielsen, Eckhard Weymann

The book with all the articles is available at http://hjem.get2net.dk/intuitive/vermittlung
en
Research supervision: Developing a community of enquiry

David Aldridge

Abstract

The process of supervision is one of development, it involves mutual learning and often one experienced person facilitates the development of another. Mutual influence does not imply equal influence, yet each contributes to the interchange. We are faced with a relative lack of research expertise in supervision. It is vital that we develop a sound basis of research-oriented clinical practitioners. While we are developing clinical supervision and training for clinical supervisors, we are lacking in training bases for research supervisors.

Over the past fifteen years we have seen an emerging demand for music therapy research in Europe. A number of research initiatives based in different countries throughout the varying continents have attempted to promote music therapy research. Music therapy itself, like nursing, psychotherapy and various other forms of helping professions, is also being challenged to produce research results.

The source of that challenge is coming both from within the profession itself, and from without. From within the profession, a new generation of music therapists is demanding academic credibility, and this need is linked to the establishment of postgraduate music therapy courses leading to masters and doctoral qualifications in several European countries. Music therapists want to gain academic credentials by further study and deepen their understanding of what they are doing in clinical practice. Combined with this internal demand, we are seeing an external demand for outcomes research related to varying therapeutic initiatives both from third-party funders and from employing health institutions. With Government cutbacks in health and education, enhanced scrutiny in University spending, and fiscal demands for efficiency and productivity, then music therapy departments are having to either justify their existence by producing material evidence of their efficiency or produce research papers to improve their academic points rating. This means that a relatively new profession is being forced to develop research results without having had the chance to establish research training, without a satisfactory background of research material and without the opportunity to negotiate an acceptable way of doing research that is related to therapeutic outcome. Indeed, we are not alone in this, rehabilitation medicine and general medical practice in the Western world stands under the same spotlight of scrutiny.
Teaching research

From these requirements we are encouraged to produce research results, which demand particular and appropriate research approaches. People often want formulas and routines to do research. My favourite example follows from the work that I have done using Kelly’s Repertory Grid technique (Kelly, 1955). I am asked where to buy the computer program that I used and what list of literature that I have that will inform the would-be researcher. But no one has yet asked me to teach him or her this approach. However, if I asked you as a music therapist for the score of a piece of music that you had played, so that I could play it myself, you might be sceptical of my ability to perform it if I had had no musical training. So it goes for research, the program, like the score, has no meaning alone. We have to develop a community of inquiry that accepts that research approaches must be taught.

My cousin George worked down the pit. He was a coal miner. Shortly before his retirement he decided that the best way to spend both his time and money would be to buy a piano. He wanted to play like me, he said. So I arranged to give him the musical scores that he liked to hear me play—“The Blue Danube”, “Kitten on the keys”, “Sidesaddle”, “Happy days and lonely nights”, “La Paloma” — and off he went with a pile of sheet music. After collecting his redundancy pay, he bought a piano that took its pride of place in the family living room. A month later I telephoned to ask him how his piano playing was going. “Terrible”, he said, he had sent the piano back. It didn’t work. When I asked him if he had had lessons, he said “No”. He assumed that because I could do it, so could he. And the same thing goes for music therapists who would be researchers.

A lack of research supervisors

We are faced with a relative lack of research expertise in supervision. Some of us have a research career that has experience of various forms of research projects. However, few of our colleagues have had the opportunity to do post-graduate research and are being expected to teach research methods and supervise research projects. While this may be a necessity, driven by need, I suggest that in some cases we will find that colleagues are being prepared for an over-idealized world of academic research that reflects the lack of research experience within the profession, while we need research that is focused upon clinical practice. It is vital that we develop a sound basis of research-oriented clinical practitioners. While we are developing clinical supervision and training for clinical supervisors, we are lacking in training bases for research supervisors.

The foci of research

There is also a difference between the purposes of research. At the moment, in a junior profession we have researchers preparing masters material and doctoral studies. These studies are often of a different nature to post-graduate research studies and research contracted to outside agencies. Doctoral studies are focused on the development of the doctoral candidate. They are there for the sole process of developing someone who will later be able to carry out research. Therefore the work itself will often be of an intensely deep and inward-looking nature. For my doctoral students, the process of research is a developmental process. The content of such research is not neutral; it reflects the personal concerns of the student and their needs. Not only am I concerned with the development of a scientist/researcher but also a clinical practitioner.
Sometimes that very researcher is an experienced clinician and must balance this with being a novice researcher. If the researcher has battled through the profession, establishing his or her position within an institution and struggled to maintain a credible professional identity, to be cast back to the stage of novitiate is a challenging task; hence the need for sympathetic and sensitive supervision.

The research that is carried out by experienced researchers will be more outward looking and often be at the request of some external agency wanting to see some material benefit from their investment. Therefore, the purposes and the methods used will differ. I am arguing that we need both these forms of research, and only to foster an inward-looking research will restrict the nature of music therapy research, and thereby practice, in the future.

What kind of research we do, and the methods we use to go about researching, will be influenced by the philosophy of science that we have. My main proposal has been that science is a process, an activity not a set of commandments set in stone for all time as the basis for a dogma. In a post-modern world, where all the major themes are challenged and deconstructed, then it is our responsibility to construct themes that are appropriate to the knowledge that we need. While this debate is often set out as differences in truth claims; that is, “Is truth relative?” or “Is there one truth?”, my argument is that such a position belongs to a previous era of debate. Claims about truth have already been discussed in various other scientific disciplines. What we are really making claims about is local knowledge. This debate can be currently found in the nursing literature, in the world of psychology, in journals dedicated to social science and, particularly over the last ten years, in the field of complementary medicine.

Supervision

“...a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in clinical situation”.

“an interpersonal process where a skilled practitioner helps a less skilled or experienced practitioner to achieve professional abilities appropriate to his role”

John Fowler 1996 page 472/473

A further debate that has emerged from other health care professions is the need for clinical supervision (Fowler 1996), and is one that we can also transfer to the needs of research supervision. At the heart of this need lies a paradox: How do we supervise “artists” with their needs for individualism and self-expression that go beyond normative expectations. Yet, we are not solely concerned with art, nor patients and practitioners as artists, but with “clinical practice” in particular settings.

Psychotherapy supervision research (Watkins 1995) has attempted to draw some conclusions about how supervision plays an important contributory role in developing therapeutic practice in that supervision is considered to be relevant to both practice and professional identity. The developmental stages of becoming a therapist are emphasised, and it is to these stages that the supervisor should tailor her interventions some of which will
to stimulate self-reflection in the supervisee. However, despite the importance of supervision there appears to be little formalised training and an expectation that supervision can be learned through experience. There appears to be an assumption that the good therapist will become a good supervisor (Allen et al 1995). Similarly, experienced supervisors also appear to believe that because they do it, they are doing it well. The role of the supervisor and the processes involved for the supervisor herself are critical concerns that we face. In a profession that sometimes struggles to maintain its self-esteem and yet exhibit its fair share of narcissism, the questioning of competence, as artists or therapist, is a process that places the concept of supervision in jeopardy. Similarly, we can also make the mistake of thinking that a good therapist will be a good researcher. One of the difficulties faced by the clinician wanting to do research is that he or she will have to question the very foundations upon which the therapeutic work is based. Again, in a profession where acceptance has only been newly gained, and often through personal struggle, then the willingness to question the foundations of practice, a questioning that is at the heart of research, is not easily accomplished and may be the reason that we experience some resistance to the idea of clinical research. As an experienced music therapist told me, “Research will take away the magic of my work”.

**Supervision and supervisors**

The process of supervision is one of development, it involves mutual learning and often one experienced person facilitates the development of another in a mentoring relationship (see Table One). Mutual influence does not imply equal influence, yet each contributes to the interchange. However, as in all personal relationships, transference issues may occur. Conflicts in therapy may be transferred to the process of research supervision. The way in which a supervisor has been trained, and the acceptance by her trainer of her subjectivity, will influence the way in which she then supervises others. The aforementioned struggle for professional acceptance may occur in the supervision particularly when germinal ideas precious to the therapist are being discussed. Furthermore, in modern practice then we must be aware of status, power and gender issues particularly where this applies to academic supervision. And, just as transference issues occur, then there is the possibility for counter-transference.

A task facing the therapist is that supervision is NOT therapy and that is difficult for some therapists as supervisors in that there is the tendency not only to teach but also to correct. To enter such a relationship skews the nature of the supervision and is the reason that some suggest that supervisory goals are negotiated before supervision begins according to the nature of the supervision that is required. These requirements will be different according to the needs of the researcher and the supervisor. While the personal needs of my students are my first priority, for example, once they embark upon a path of formal academic accreditation then there will be institutional requirements that must be fulfilled. The dangers are that unless the motivational goals for research are established and the mutual needs of supervisor and supervisee established, then there is always the danger of the supervisor indulging in a narcissistic monologue.

Where the supervisee as novitiate researcher has an established clinical expertise then the danger is that research is pursued without the element of "search" which simply becomes an act of "re-justification". What are needed are the skills to identify and negotiate learning objectives and encourage the ability for self-reflection and evaluation.

The choice of subject matter is an important part of the process of research. Not only do we need to negotiate the purposes of research with those students that we have within our own institutions, the very nature of the research subject matter will set the tone for the consequent supervision. For example, a colleague of mine is researching into the nature of melody and its application to the clinical changes for a woman after the removal of a breast following breast cancer (Aldridge, 1996b).

For her supervision it was necessary to discuss the ramifications that breast cancer had for her, the therapist, as a young woman and the implications that melody had for her as a music therapist. As expressivity is linked to melody in our culture and a lack of expressivity is linked to breast cancer, then both aspects of her future research were intimately linked.

It is such concern with personal meaning and the nature of the research subject that we must face in research supervision. A research journal can be an important tool in this respect.

At the heart of supervision lies a paradox because part of the research supervision role lies in teaching, as well as encouraging expertise and fostering personal development. Teachers pass on tradition and stable knowledge and are therefore conservative, even if they advocate...
challenging knowledge it is from within a particular perspective. Researchers are by their nature subversive and will question the foundations upon which that knowledge is built. Again, I would return us to the consideration of research setting. Clinical practitioners in local authority settings carrying out outcomes research will have quite different research and research supervisory needs than doctoral students preparing their work for an academic examination. For example, with my doctoral students I expect that they will be embarking upon a voyage of personal development as well as an excursion into the delights of academia. We need then to develop a practice where we can offer supervisor training. Within the literature there are a variety of terms that allow for varying constellations of supervision, that is, as clinical supervisor, as mentor, as supervisor or assessor (see Table One), each offering a varying emphasis on professional development, pastoral support and assessment.

Rather than criticise current research supervisors for their lack of experience, it may be a positive step forward to offer them a supervision group where there skills can be enhanced. The need to develop a culture of supervision has its grounds in that we are asking people to be therapists, artists and teachers. There are differing expectations of newly trained colleagues in a profession that itself is young. We would complain if anyone practised therapy without adequate training, yet we expect therapists to teach and do research without any training? There is a “myth” in the counselling literature (Maki and Delworth 1995) that if you are a good therapist then you must also be a good supervisor.

I suggest that maybe the same myth exists in music therapy too and that we must develop our supervisory skills both for research and at the same time this will address the needs in music therapy practice. Similarly, while some of us may be competent researchers, it does not necessarily follow that we must be competent research supervisors. While some researchers may have experience of teaching undergraduate students and supervising dissertations, it does not necessarily follow that the same experience can be grafted onto postgraduate research supervision. This is further compounded by the fact that those music therapists pursuing postgraduate research may be advanced practitioners BUT novice researchers, and it requires considerable skills on the part of the supervisor to acknowledge clinical competence in the student while concurrently fostering a research readiness.

This situation is reflected in the difficulty of asking would-be researchers, who are skilled practitioners experienced in presenting “case studies” to move to another level or research analysis. Similarly, we may also have competent researchers pressed by their institutions into supervision and it is appropriate to ask those supervisors what their supervisory requirements may be as novices while maintaining a recognition of their clinical or research expertise. None of us like it when we have struggled to reach a position in our careers, based on a recognised expertise, to be returned to a position of novice. But such a position has sometimes to be tolerated before we can learn something new.

**Teaching and individualism**

A new generation of music therapists is being trained that demands a choice of learning approaches which suits its approach to music and to therapy. The
pioneer approach of the teacher/pupil relationship no longer holds sway, and while the restriction of the relationship may be lost, so too is the security. Furthermore, as there is no established tradition of music therapy research, we have the luxury of deciding what methods are appropriate to use in our scientific endeavour. While some of us will research alone, others will decide to work together in groups. What we need to avoid is that one group can make an exclusive claim to determine the doing of knowledge according to their own principles; that is, only quantitative or only qualitative. To establish tolerance we need to understand each other and our varying purposes and develop methods that are appropriate to those purposes.

The activity of doing research is concerned not with restricting us to a one-dimensional sense of being according to an accepted orthodox world-view, but the possibility for the interpretation of the self as new. What we choose to know, and how we know is a matter of judgement, and therefore one of moral agency. How each one of us decides to know in the future, with whom we share that knowledge, and how we tolerate and incorporate what others know, will determine the scientific culture of music therapy. As we know from the supervision literature, the process is one of developmental stages for both supervisee and supervisor, some of which will be concerned with competence and identity. We have to go through these transitions and to do so inevitably brings conflicts. A necessary first step will be to recognise the competencies of others from which we can establish a shared platform of expertise rather than to promote some of the current narcissisms that hinder our development.

While a benefit of music therapy training is that it promotes individualism and allows for the unique expression of clinical expertise, the danger is that groups then form that are so convinced of their own unique value that they believe all others should work in their superior way and they have the right to dictate the standards of individuals. This is tribalism and is the ultimate danger in a post-modern society. We form groups when our identity is threatened. Indeed, music therapists have struggled for years to find a voice that will be heard in the community of practitioners. However, in their searches for modern identities some have resorted to falling back on a traditional background. While this is undoubtedly expedient, and resurrects a heritage that itself may provide innumerable riches, it is also in danger of resurrecting identities that are no longer viable in current practice. Where such identities isolate from the practice of others, and make claims unique claims for knowledge that is superior, then we have the triumph of insecurity and its babbling cliques over a set of particularized understandings that may lead us to realising our community of practitioners.

Furthermore, as then teacher-pupil role is changing to the self-learning student we are promoting a linear form of learning that is dependent upon particular written texts. Our problem in research lies in that not only are there not enough texts but the process of learning from them becomes linear. As I referred to earlier, some approaches must be taught, they cannot be simply read. We need teachers as much as we need texts, and we need to promote teaching skills as much as we need to promote writing skills.

Learning of skills and a way forward

One of the common experiences that I have is that music therapists tell me “I can’t write”. So I ask them “How did you learn
to play the piano or to do music therapy”. They usually reply that they practised, had tuition and some form of supervision from a competent expert. So it is with writing. Like my cousin George and his piano earlier, we need to develop the skills.

We need to encourage a standard of music therapy writing that will bring the exciting clinical work that is being done throughout the world to the attention of other clinicians both inside and outside the profession. In our various training schemes we often fail to promote the skill of writing and the communication of clinical results. While accepting that music therapy must be learned as a set of skills, so too must the skills of writing and presentation be learned. Furthermore, we need to encourage the possibility for academic writing and theoretical discussion. This can only be achieved by a journal that will act as a forum for such debate. As our chosen medium is music, and non-verbal, then the challenge arises in these times of modern technology of developing new media possibilities. We do not need a new printed publication. I suggest that we investigate the publication of music therapy material on CD Rom. Material published in this way could be text, musical scores, musical extracts as recorded sounds, video clips, photographs and database items.

On the threshold

This paper is a culmination of informal talks throughout the world as a teacher of research and research consultant in varying institutional settings. The next substantive decision is how we address the issues raised here. There cannot be one solution as the varying schools have differing needs. However, there may be a common core of skills that can be agreed upon and this is perhaps best addressed at the level of the varying professional organisations. For me to suggest a rudimentary curriculum would be both premature and presumptuous. I would like to see a debate within the pages of this magazine as this where the voices of experience can be heard.

It is important that international connections are maintained and fostered for the discussion of research and clinical practice. One way to accomplish this will be by exchanging teaching staff interested in research, or providing the opportunity for extended visits. Promoting research placements for higher-level students, or junior members of staff, is also a possibility that would benefit the institutions. For example, we have had visiting music therapists who have sat in on the teaching sessions, experienced a series of therapy sessions and made a review of literature on a theme that has interested them. There are a number of institutions throughout Europe that have special areas of interest for music therapists, and an extended working visit is a good way of getting to know other institutions.

We certainly need to collaborate on providing a research infrastructure. By this I mean that we have to share our various resources for offering methodological advice and teaching research methods. There is enough expertise, the problem remains of how to utilise it and co-ordinate it. We have access to databases and literature archives. What we do not have, as yet, is a means of giving a broad access to such material. Setting up co-operating centres within the differing countries would establish nodes of expertise, but that would mean that they would have to communicate with each other! We also need to get to grips with the need for
research supervision. This challenge will be to offer some form of research supervision training; in other words, a supervisory group for supervisors. While we may be a junior profession with emerging abilities, we can perhaps share our competencies to mutual benefit.

One important way forward would be to promote a “single-case” agency where we could co-ordinate single case methods teaching, offer a suitable research format and collect research examples. By doing this we could develop a set of clinical studies as a clinical studies database. A clinical studies database would necessitate translating the clinical studies into a common set of European languages and offer clinical researchers a pool of comparative data.

We need to identify our common purposes. If one purpose is to develop research then we must identify the areas where skills can be taught and foster a climate of acceptance such that skilled practitioners can become novice researchers. Those novice researchers can then fast track to expert status. What this process will not give us, however, is expert research supervisors. To accomplish these steps we will need to establish a tradition of research and skilled supervision teaching. One step will be to draw from the experience of our colleagues in other therapeutic professions. This too will be a move towards a community of inquiry.

The same may apply to clinical supervision and I hope that we can begin a dialogue within these pages regarding both clinical and research supervision.


Supervision as a collaborative learning community

Harlene Anderson

Abstract

At the heart of my philosophy and practice of supervision as a collaborative learning community are three Cs—connect, collaborate and construct: Supervisees and supervisors developing relationships that invite jointly creating knowledge and unique to each participant. When we share our knowledge with one another, we cannot know what each brings to the sharing; determine how each will interact with the shared knowledge; nor predict what each will create with it. Whatever the outcome, it will be something different than either started with, something socially constructed.

I place my philosophy and practice under a postmodern umbrella (Anderson, 1997). Briefly, by postmodern I refer to an ideological critique of the tradition of meta-narratives that represent universal overarching truths and the inherent risks in this certainty tradition. Postmodernism includes itself in this critique and owns the same risks. A notion of postmodernism is language and knowledge as relational and generative. Central to this notion is dialogue as a dynamic creative conversation with room for all voices, with each person unconditionally present and with a full sense of belonging. Dialogue also entails two-way exchanges and criss-crossing of ideas, thoughts, opinions, and feelings. What is put forth in dialogue

**I prefer “consulting with” and “having a conversation about” instead of “supervision.”
is interacted with and interpreted by the other. New meanings, understandings, and knowledge are inherent in dynamic dialogue.

Conceptualizing language and knowledge as generative invite collaborative learning communities that maximize new and individually tailored learning. I will briefly describe and highlight selected aspects of one collaborative learning community—a seminar for supervisors. (See Peters and Armstrong, 1998 for an excellent discussion of collaborative learning communities.)

**Connecting, Collaborating and Constructing in a Supervisors Seminar**

**Participants**

Diversity among participants enhances the quality and quantity of learning that is produced. Each person brings differences in terms of age and life stage, personal and professional experience, degree and discipline, theoretical orientation, work and educational setting, learning style and agenda, or any of the diversity “isms.” Varieties of voices provide a richness of perspectives and realities. A seminar might include experienced and rookie supervisors supervising in various clinical and educational settings with sundry degrees who come for distinct reasons. Often half the participants have completed the “required seminar” and continue in the next seminar because they value the experience.

**Relationships and Conversations are Inseparable and Influence each other**

To invite and maximize collaborative learning I must act and talk consistent with my philosophy. I must live it, being genuinely and naturally collaborative. This includes respecting, inviting and valuing each voice, being flexible and responsive, and creatively doing what the occasion calls for on the spot. Foremost, this includes trusting the other and our process.

I want to create and facilitate learning relationships and processes where participants can identify, access, elaborate, and produce their own unique competencies, cultivating their seeds of newness in their personal and professional lives outside our organized context. I want to talk and act to invite and encourage participants to take responsibility for and to be the architects of their learning. I also want each participant to experience our task and relationship differently from the familiar hierarchical and dualistic teacher-student relationships and learning processes they may have experienced.

Being collaborative does not mean that I deny or ignore my wealth of ideas and experiences, but that I too must be a learner, believing that I can learn as much as the participants. Importantly, collaborative teaching and learning challenge participants and me to reconstruct how we think about teaching and learning.

Nor as critics and skeptics of postmodernism often believe does the perspective discount previous knowledge and experience. Participants find that this is not the case. The difference is the intention with which that knowledge and experience is used.

Towards these ends collaborative learning begins with the first conversation I have with each participant whether in person or by telephone. I show a keen interest in
learning about the person and preview my expectations and agenda for the seminar, being forthright about my prejudice for learning and knowledge from a postmodern perspective are also important.

**Inviting Collaboration by Doing**

Collaborative relationships and processes spontaneously emerge out of the experience itself, learning by doing rather than through lecturing about or instructing participants on how to be collaborative. At the first seminar I say that I have many ideas and experiences to share but that I need their help in selecting out what to share. I do not want to unilaterally select. Toward learning about them and they about each other I invite participants to form small conversational clusters. I might pose beginning questions such as: What are your expectations of supervision and of me?, what is your learning agenda?, how do you learn?, and what do you think is important for us (I tend to use collective language) to know about you and your everyday contexts that would help us best meet your learning needs? I do not expect answers, the questions serve as starters. Clusters might respond to all questions, address only one, talk about something different. I ask each to record the generated material on a large tablet, a small pragmatic action that enhances engagement and conveys my serious interest in their voices.

The clusters reconvene and share the highlights of their conversations. I post their tablet sheets on the wall. We might ask questions to make sure that we understand their thoughts or participants might clarify with each other. Through this process, and at each meeting thereafter, participants add to our agenda and prioritize agenda items and ways to address them.

**Selecting and Addressing Content**

Collaborative learning occurs within a broad context of expectations, including credentialing and licensing bodies, professional associations, work settings and the discourse of top-down knowledge. I keep in mind that multiple investors hold distinct assumptions about the learning purpose and how learning will be accomplished. I also realize that my role bestows power and authority on me as a teacher and supervisor, placing me in hierarchical position. I hold the personal freedom, however, to choose how to exercise that power and authority. What I am most interested in is how can I position myself within these contexts and assumptions to best offer what I have to offer, and for the learner to summon control over his or her own learning.

I give participants seminar syllabi that include a variety of topics required by external institutions and those deemed important by me. Participants have a voice regarding agenda and forum. One may volunteer, or I might invite someone to share a supervision experience related to a content area and to choose the way to address the experience and content. For instance, she may seek a consultation, or request another participant interview her, followed by a general discussion, a reflecting process in which the participants listen “as if” they were a part of the cast of characters in the supervisory dilemma (Anderson, 1997; Anderson & Rambo, 1987). Participants may bring their supervisees to a session. The supervisor and supervisee direct us in how we might be helpful to them—whether performing their supervision as usual with us as
reflectors, or being interviewed by another participant. They might simply want a fresh perspective or they might have a specific question. If there is no preference we might offer suggestions and they tailor a choice to suit their needs.

A primary vehicle for content is dialogue, sometimes occurring in relation to a reading, videotape, experiential exercise, consultation, or shared information by facilitator or participants. Content is seldom entirely covered in a discrete time frame or as a discrete entity. Instead, a variety of content weaves throughout each session and throughout the seminar in various ways. The content agenda is always so full that participants do working lunches, clustering around content topics. As one participant put it, “Agenda building is a great tool--to state what is important, puzzling, exciting--so that everyone’s needs are stated, even though there may be too many items to address!”

Reflecting Promotes Self- and Other Dialogue

An important part of learning is reflecting with oneself and others, putting silent thoughts into spoken or written words. I incorporate reflections in a variety of ways. Throughout each session I openly reflect on our process and relate it to my postmodern bias and their learning. I have designed various experiential and consultation exercises with reflecting components.

I give participants a reflection sheet at the end of each session, asking them to share their after thoughts at the next session. Reflections might focus on their experience of the last session, how they used their learning, new thoughts or questions, new agenda items, or recommendations for my role as facilitator. Participants say the reflection sheets are a valuable learning tool. Writing the reflections provides a way to keep the seminar process alive and a forum for self-dialogue.

The reflection process furthers several interrelated purposes. It consistently builds in continuous self, other, seminar, and teacher evaluation. It encourages learners to be active and purposeful in their learning and in determining its direction. It encourages reflection as part of everyday practice among supervisor and supervisee and among therapist and client.

I silently read their reflections at the beginning of each session and incorporate what I learn. Importantly, the reflection process helps me continually learn the participants’ changing needs. Their reflections provide an opportunity for me to improve my teaching/facilitating and adjust my style to best serve their individual and combined needs--to accommodate to what each group, occasion, circumstance, and relationship calls for at any one time.

What we have Learned about Collaborative Learning

Although collaborative learning is often mistaken as unstructured learning, participants find it is simply another kind of structure. Participants overwhelmingly report that the learning process is more important than the content. Participants consistently report amazement at the richness and meaningfulness of the process. They comment on the generativity of the conversations, the emergence of new learning, and the surprising changes in their thoughts and practices. They express gratefulness for the opportunity, although at first unfamiliar and challenging, to be
thoughtful active learners. They appreciate and develop the richness of possibilities as they move from a need for certainty and closure to a sense of comfortableness with uncertainty and the yet-to-come. In one participant’s words, giving “a new sense of self-confidence.” As a learner in group supervision put it, “The atmosphere beckoned to me, ‘Take a chance’.”

Participants report that the new learning is useful in their everyday work. They learn to appreciate what their supervisees bring to the table—listening and hearing it differently. As one participant said, “respect for the supervisor-supervisee relationship as well as for each of their positions—that no one position is of greater importance than another.” One said she valued learning to talk about supervisees and clients with “critical thinking and compassion” rather than with a pejorative and judgmental attitude. Another said, “I am constantly amazed at how my supervisees change, as they are willing to learn more about their client’s lives, their struggles, their histories. Their negativity usually reduces in proportion to their openness. I amaze myself when I am willing to be more open-minded as well.” And another reported, “My supervisees have reported that my non-hierarchical and collaborative model of supervision is refreshing compared to precious supervision in which the supervisee feels intimidated and judged.” These experiences with supervision as a collaborative learning community reported by supervision seminar participants and their supervisees are consistent with other accounts of supervision from a postmodern perspective (Caldwell Caldwell, Becvar, Bertolino & Diamond, 1997; Anderson, London & Punsky, 2000).

Also noteworthy is that participants express pride of ownership in the seminar and accountability for their learning. They also describe a new sense of responsibility to each other, congruent with McNamee and Gergen’s (1999) notion of relational responsibility. That is, as one positions oneself differently with another—as I position myself differently with learners—we boldly experience that no one holds sole responsibility. When responsibility is shared—as participants connect, collaborate, and construct with each other—the learning relationship and process are more mutually gratifying and rewarding.


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Short biography

Harlene Anderson, PhD.
Harlene Anderson, founding member of the Houston Galveston Institute and Taos Institute, is recognized internationally as being at the leading edge of postmodern collaborative practices as a thinker, clinician, educator, and consultant. She takes her tools—her insights, her curiosity, her engaging conversational style, and her keen interest—to help professionals turn theory into new and often surprising possibilities for their clients, students, and organizations. She embodies her own belief in learning as a lifelong process—inviting, encouraging and challenging people to be inquisitive, creative, authentic, and open to the ever-present possibilities for newness in others—and in themselves.

Harlene has authored and co-authored numerous professional writings including her book Conversation, Language, and Possibilities—A Postmodern Approach to Therapy. She is a member of the editorial review boards of several journals, has presented at numerous national and international conferences and has consulted with a variety of organizations.

In 2000 Harlene received the prestigious Outstanding Contributions to Marriage and Family Therapy Award from the American Association for Marriage and Family Therapy and in 1998 she received the Lifetime Achievement Award from the Texas Association for Marriage and Family Therapy.

http://www.harlene.org
The 10th World Conference is over and many thanks from all of us are going out to the ones that gave up time from their private and professional life to make the Oxford Experience possible. It was a highly professional organization taking place in beautiful old buildings.

Many interesting current themes have been discussed, the actual state of doing and researching music therapy in several practice fields and how to inform our music therapy community about what is going on in the music therapy world. Again the manifold perspectives about how to do music therapy and how to train music therapists showed that we all share the music but we have different ideas about how to talk about it. A nice thing about music therapy conferences is that we meet during the day to discuss what we think and do but in the evening and the night we shared why we are there: the music.

Just to remind all of you that have not send or brought their article for the conference proceedings to Oxford. The deadline for sending your work to the congress office is the first of October 2002 (10/1/2002). Here is the address: BSMT, for Prof. Leslie Bunt, 25 Rosslyn Avenue, East Barnet, Hertfortshire, EN4 8DH, UK.

Anyhow, it is the beginning of August and here is our new issue of "Music Therapy Today".

Good news first! "Music Therapy Today" is registered with an ISSN number and this means for you as authors that publishing your work in this online-journal is citable. And again I have to stress that the copyright will stay in your hands. To say it again and again, www.musictherapyworld.net is a service site, it is a network (.net) for you and it is not a commercial (.com) endeavour.

In this issue our spotlight falls on work in neurological rehabilitation. We also
wish to announce that our **discussion board** has opened up for debate. Simon Gilbertson has taken over the duty of being the editor of this board on neurological issues. He will edit the incoming contributions for suitability. A clinician has been recently personally attacked in a discussion board and the publisher was sentenced for being responsible. So please be gentle and think before you write.

To get an impression of the range of interests Simon has, I'd like to start with his article *Places To Learn - A Contemporary Demand For Student Placements In Music Therapy*, which features his reflections on clinical practice and training issues. He has worked for eight years as a music therapist and head of music therapy department in a neurosurgical rehabilitation clinic in Hattingen, Germany before he joined our research team here at Witten/Herdecke University in April. Read his statements about what music therapists working in neurological rehabilitation should be aware of.

Concetta M. Tomaino, Director of the Institute for Music and Neurologic Function at Beth Abraham Health Services in New York City, shares some of the same thoughts. She claims, *The music therapist must have an understanding of the various disease and neurological processes to adequately assess functional ability and plan appropriate use of music for the course of treatment.* Her article on *The role of music in the rehabilitation of persons with neurologic diseases: gaining access to `lost memory' and preserved function through music therapy* sheds a new light on memory processes. Memory as researched in medical science is mainly focused on its cellular level and functioning during accessible serial memory processes. Music memory seems to work much more in a holistic, or as Pribram has proposed for complex processes, in a holonomic manner. Read what her impressions on music, therapy and brain function are.

Situationalist approaches which discuss the role of situated cognition is another stream of thoughts which tries to get closer to the solution of how and why information is stored in a complex network of neurological circuits and hemodynamic processes of the brain. I am happy to share with you some new work done by Gudrun Aldridge. She asks: *How do we listen in different situations and what are the components that are allied with the activity of our*
listening within the therapeutic framework?" Her article on "Cycles of listening for identifying incidents of therapeutic significance in clinical improvisation" divided between hearing, listening and perceiving and gives us an insight into the scientific debate on these issues.

And as we go back to the music, Dementia is the scope of Barbara Dehm-Gauwerky's article "When the present has become a mere stage for the past - music therapy in the case of a patient with extreme dementia". It leads us back to the direct work with a patient and their presence in the music. This article presents and reflects the music therapy session with an Alzheimer patient.

In medicine there is a contemporary movement, which focuses on evidence-based medicine. This approach follows ideas of Archie Cochrane who started to discuss outcome and effectiveness of medical studies and treatment. Practitioners should be sure about the appropriate evidence of chosen medication and methods to achieve evidence. Therefore, the statistical tool of meta-analysis and systematic review methods of published studies was been developed further to compare studies with same methods, samples and outcome. This movement of medical research has become more and more used as an evaluation tool for the quantitative effectiveness of treatment methods within the medical range -it is political and controversial. The article "Evaluation of Music Therapy in German Neurorehabilitation - Starting Point for European Comparability" from Annkathrin Poepel, Silke Jochims, Norbert van Kampen, and Holger Grehl is based on a talk given at the European Conference for Music Therapy in Naples, Italy in April 2001. They have made a literature review on music therapy in neurological rehabilitation. Read what they found out about the work being done in Europe.

I `d like to end with a quote from Dizzy Gillespie

"First you learn your instrument.

Then you learn music.

Then you forget both of those and just blow."
Until we read again

Joerg Fachner
CYCLES OF LISTENING FOR IDENTIFYING INCIDENTS OF THERAPEUTIC SIGNIFICANCE IN CLINICAL IMPROVISATION

Gudrun Aldridge

1.0 Abstract

The activity of listening within the context of music therapy is a complex and personal matter. In contrast to ‘hearing’ that relates to our ability to perceive sounds with the ears, the connotation of listening is connected with attention, concentration, and focusing on something or somebody. The act of listening is a perceptual/cognitive, as well as an emotional act. Our natural predisposition is that we perceive music holistically. The unity of the cognitive, gestural, emotional and relational is the strength of active music therapy for it is directed towards the phenomenon of experience. The question is: How do we listen in different situations and what are the components that are allied with the activity of our listening within the therapeutic framework? We may have experienced that it is not easy to differentiate one’s own thoughts when being emphatically involved in the event itself. How we as therapists experience the other person in the music is of paramount importance for the therapeutic course and success. According to place, time and situation our listening activity demands flexibility. Structuring listening activity prepares our thoughts and feelings for gaining the necessary consciousness to interpret what is being performed.
2.0 Introduction

To understand what we are doing in the clinical practice of music therapy, we need to listen to what has been performed in the therapy session and analyse this performance for its significance.

In the following I want to discuss a strategy of listening and how this may be related to improvisational analysis.

3.0 Listening, hearing, perceiving

Listening to somebody or something means that we make an effort and are prepared to hear something (Hornby, 1998). The term also indicates that we allow ourselves to be persuaded by another person, who makes a suggestion or gives an advice. In contrast to ‘hearing’ that relates to our ability to perceive sounds with the ears, the connotation of listening is connected with attention, concentration, and focussing on something or somebody. The term perception points to something more comprehensive. We perceive holistically with all our senses, not just with our ears. From a philosophical perspective (philosophy of empirism) we perceive the world through our senses and make sense of it by the dimension of our mind. This non-sensory process of cognition is, as Aldridge (Aldridge, 1996) explains, rather silent and appears as if listening were solely connected with a sensory experience. But what we also perceive is the meaning of what we hear.

3.1 Natural basis of listening

Prerequisites of listening point to its natural basis, that is our potential of attention and our ability to estimate and localize the sources of sound. Music listening activates and engages the sensitive, fast-working and complex auditory perceptual processes essential for spatial orientation as a means of biological survival, so the sound of music hits a powerful natural potential of sensory experience that is a natural predisposition of every human being (Christensen 1996).
As we listen to music our short-term memory is constantly active, retaining auditory images of musical events for a short while. According to McAdams (McAdams 1987) incoming information can be stored in short-term memory and kept in an active state for at least 5 or 6 seconds. The retention in short-term memory permits the experience of coherent musical entities, comparison with other events in the musical flow, conscious or subconscious comparison with previous musical experience stored in long-term memory, and the continuous formation of expectations of coming musical events (Christensen 1996). Furthermore listening is by its nature a private, and internal experience. It is pluralistic and fluid; listeners make use of multiple cognitive frameworks and shift their strategies from one moment to the next (Cook 1994). To sum up, the act of listening is a perceptual/cognitive, as well as an emotional act. Our natural predisposition is that we perceive music holistically. The unity of the cognitive, gestural, emotional and relational is the strength of active music therapy for it is directed towards the phenomenon of experience.

3.2 Components influencing the activity of listening
The question is: How do we listen in different situations and what are the components that are allied with the activity of our listening within the therapeutic framework?

<table>
<thead>
<tr>
<th>Modes of Listening</th>
<th>Components allied with the activity of listening</th>
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<tbody>
<tr>
<td><strong>Empirical Listening:</strong> Therapy room. Experience in itself, partially understood. <strong>Immediate, direct, close</strong></td>
<td>Element of participation Performance Action and purposeful movement</td>
</tr>
<tr>
<td><strong>Open Listening:</strong> Change of time and place. Overall impression and revelation of essential features of session/improvisations from different perspectives. <strong>Open-minded</strong></td>
<td>Phenomenon of experience Concept of being as musical being</td>
</tr>
</tbody>
</table>
Table 1 on page 3 displays an overview of some modes of listening and components allied with the activity of listening. While the quoted components may occur in all modes of listening, the components Element of participation, Performance and Action and purposeful movement seem to be prevalent in what I have called Empirical Listening. In the following I will comment on both, the modes of listening and the related components. Examples taken from therapeutic improvisations as well as illustrations shall clarify this further.

### 3.3 Empirical listening

Listening takes place in the therapy room out of one’s own experience. We can term it empirical listening. It is immediate, direct and close, and includes feelings and thoughts aroused during or after the improvisation. Our perceptual/emotional listening is coloured by impressions, images and physical movements. Here music appears as action, it lives and exists in the moment and therefore is only partially understood.

Spontaneous notes, written down immediately after the session, are helpful to catch the overall impression of the session.

It is obvious that listening is very much connected with the phenomenon of experience and therefore can be regarded in connection with the philosophy of empirism. The knowledge of the world is gleaned through experience. It comes through the senses that meet the ear. The non-sensory factor involved is that of cognitive perception, the dimension of the mind. It is a process of organization where meaning is imposed upon what is heard. To perceive then is to give meaning to what is heard, an act of identity. This fact points to the two-dimensional quality of listening: Listening is focused on what is played outside one-
self, and points to that what is realized within oneself. What is heard from outside is realized within (Khan 1991, p. 253). We can then say that hearing is the perception that a tone is being played. Listening is the consciousness knowledge of that tone and the intention to understand its meaning.

In this context we have to remember that the non-material process of organizing incoming sensory sounds and shaping meaning from it cannot be exactly located and measured by manipulated instruments (Aldridge 1996b). It is one of the reasons why there has been little success in presenting satisfactory explanations to describe the process underlying the perception of music.

If listening is closely connected with generating meaning, how can we then develop a clear picture of the process of identification and how can we make this clear to our colleagues? I will refer to this issue later, when explaining the Index of analysis and interpretation.

Other components that are attached to the mode of Empirical Listening are: Participation, Performance and Action and Purposeful Movement.

As two individuals improvise together listening is related to performing. Listening and performing in the musical relationship, that is, action and purposeful movement in a relational context, appear to be the building blocks of developmental change and of relevance for cognitive change (Aldridge 1996b, p. 269). We have to remember that these factors are pre-verbal, and not language-dependent.

When participating actively the patient appears in the role of a musician. Although he may deny his musical abilities the fact is that when he plays a rhythm he enters to become a musician. It is this performative aspect in music therapy that offers us a broader perspective that may enhance our listening activity towards the entirety of the performing person. We may listen to the person as a piece of art, that will free us from a pathological viewpoint. As such listening is directed towards aesthetic expression and encompasses unique potential traits of the patient, relating to the patient as musical being.

The concept of being as musical being naturally states our human abilities to respond to events in time, to create and develop ideas and respond and react to atmosphere. It is based on David Aldridge’s concept of self, regarding the self as a performed work of art. His phenomenological approach (Aldridge 1996b) suggests a correlation between musical form and composed human form. By regarding the identity of a person as a musical form that is continually being composed in the world, we may be able to listen to the different
modes of how this person is in the world. Thus we might gain an understanding of this person as a physiological, cultural, social, and sentient being. It means that the listening activity goes beyond the musical material itself. It concentrates on relational aspects that appear between two individuals, the individual and her situational context, and between the individual self and her internal processes. In this way listening is closely attached to the relational context.

The following illustrates important relational constellations that emerge in therapeutic improvisations:

**FIGURE 1. The relational context in therapeutic improvisations. Process of interaction.**

The active playing of an instrument demands that the client listens to himself and the therapist who in turn listens to, and plays for and with him. The activity of listening and the activity of participating determine the modes of relationships between patient, therapist and music. It appears between and among tones, between music and self, and between the two persons who are involved in the therapeutic act. It can be perceived when we concentrate on how patient and therapist make use of the musical elements and how they relate to them. It also reveals the relationship with the mutually performed music and how patient and therapist relate to each other, encompassing physical and psychological responses.
This may be influenced by intercultural differences. We must admit that even within a clearly defined therapeutic framework there is an infinity of nuances of relationships present that may control or guide our listening activity, and may be difficult for us to detect.

Two extracts from an improvisation may serve as an example of the incidence of intra- and intermusical relationship.

**Audio example (Gudrun_Web_1.mp3)**

**Extract 1 (P. Steeldrum; Th. Piano):**

In the beginning of the example your attention might be drawn to the voice of the steel-drum, being in the foreground with action and patterns being strung together. What you may also notice is the length of intervals and the frequency of the highest tone c2. The voice of the piano, played by the therapist, is in the background and hardly perceptible. There seems to be no relation between the two. While building up his music without any reference to the therapist, the patient’s intramusical relationship is in the foreground.

Later we hear a turning in the voice of the steeldrum (patient) towards the voice of the piano, giving room for it (therapist) and moving along with it in a slow steady mode. We also hear that the patient steps out of this mutual movement with a motif that develops into a short melody. A change towards intermusical relationship takes place.

**Extract 2**

Another layer of relation occurs in the second extract of this example, when patient and therapist relate to each other, responding mutually to the quality of sound, timbre and mood. The intermusical relationship is discernible in the fusion of the two voices. A change in timbre is audible: from a hard, sharp, clattering sound to a soft, carrying, resonating sound.

Here listening opens up what makes sense for both, patient and therapist. It opens the senses for a new experience: the surrounding sound leaves no distance between self and music, and between two persons. This can lead to a new insight and knowledge (moving from the expressive to the reflexive insight). Here the joint listening and performance overcome differences.
3.4 Open listening
When we listen back to the session the context has changed, like time and place and we are emotionally removed from the session. Our overall impression from empirical listening may direct us in listening openly on a global level to parts of the session. This may confirm our intuition and impression that arose during the actual session. Many therapists refer to this mode of listening (Bruscia, 2001), also described as holistic listening (Lee, 1995) or second listening (Pavlicevic, 1997) with the intent to detect aspects that were perhaps hidden and coloured by the empirical listening in the actual session. This mode of listening is open-minded and attempts to listen freely from many different points of view, giving room for intuition. Keeping the openness in mind the therapist may listen in the role of an improviser or an outstanding listener who has stepped out of the emphatic and reactive context.

3.5 Focussed listening
Depending on the therapist’s decision on what parts of the session she wants to focus on, this mode of listening can be focussed on certain events of the improvisation, including salient elements of the musical & extra musical material. This mode of listening is characterised by its distance from the initial event and by analytical determination. On this level music may appear as object. In listening to the “What” (aspect of content) and “How” (aspect of relationship) may establish facts about technical aspects of the performance, the personal involvement, feelings, interpersonal responses and the direction of the therapeutic course.

In order to organize and structure the activity of listening I have generated an Index that takes into account the dyadic interaction of patient and therapist and the therapist’s reflections. The aforementioned phenomenon of experience and its closely connected process of generating meaning has been taken into consideration. For this reason the Index is built on thoughts of elements of phenomenological research and takes the fact into account that in talking about and describing therapy we are always at several steps removed from the actual phenomenon, the experience of music in the moment of its genesis. This fact implies the necessity to differentiate between the immediate experience of individual expressive action and its description and interpretation. With this aim in view the terminus of the three levels of interpretation (common in modern linguistics) has been chosen.

The following illustration displays the Index.

### Explanation of Index:

**(session)**

As analysis and interpretation occur some time after the therapy session level 1 (experience, parole), that refers to the session itself, is not part of the Index. Level 1 is identical with the recorded material. According to the semiologist Nattiez (Nattiez, 1990) it is the body of music.

**(level 2)**

Level 2 uncovers the basic material of the patient’s and therapist’s voice. Here we have “What” (aspect of content: music, words, gestures, movement, and pattern of interaction) has been expressed, and “How” (quality that refers to the aspect of relationship) something has been expressed.

It is the level of revelation and description (usage) that emerges in our consciousness, where we put a name to what is going on, using lexical labels, and musicological terms. This level demands a description, which is itself based on a theory implicit to the therapist as listener. However it is accessible to verification and can be re-checked with the recorded material (level 1). The data can be transcribed in graphical or notational symbols.

**(level 3)**

---

### Table 2: Index for therapeutic analysis and interpretation

<table>
<thead>
<tr>
<th>LEVEL TWO descriptive Musical language</th>
<th>LEVEL THREE interpretative Therapeutic language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basis of musical and extramusical Data.</td>
<td>Music Therapy Commentary</td>
</tr>
<tr>
<td>“What” and “How”</td>
<td>Personal remarks</td>
</tr>
<tr>
<td>Patient</td>
<td>Therapist</td>
</tr>
<tr>
<td>Patient</td>
<td>Therapist</td>
</tr>
</tbody>
</table>

---

“Significant moments” Personal response
On level 3 the listening activity is focused on significant moments (therapists use different terms for those incidents), which are important for therapy, and on what makes those moments important. The listener identifies those moments which are significant in terms of therapeutic development. They appear as music therapeutic commentary.

The therapist’s attention will also be focused on her personal response to the patient’s and her own play. Her observations may include the patient’s and her own emotional responses to inner processes, like the impression of holding back, or difficulties in coming out. If the therapist recognises meaningful moments it is important to take responsibility for her own experiences as well.

It is the level on which transference and countertransference can be detected.

On this level a qualitatively different perception is required that sometimes can be expressed only metaphorically. On this level of interpretation the therapist has to reveal the relationship between the music therapeutic activity and the process of healing.

Based on the phenomenological view of listening, the Index reflects a particular way of organizing the material and stimulating consciousness on different levels of interpretation. The Index clarifies a process of abstraction that is unavoidable as soon as we start to describe situations. Moving from one level to the other means to move to a phenomenologically reduced level. The advantage of this is that we gradually develop an awareness for our own quality of description and interpretative discourse. Focussing our attention to certain elements and knowing at which level we are talking will aid our discussion and prevent confusion. Inference and conclusions are connected with what has been done, that means with the experience through action, and can be comprehended in this way. The Index enables the therapist to explicate both what is taking place and her understandings related to what is taking place.

**Audio example** Gudrun_Web_2.mp3

A short audio example will give a practical picture of how the Index may be used. It involves the instruments metallophone, played by the patient, and chime bars, which are played by the therapist.
Your overall impression of this example might be directed towards a lively pattern of interaction that evolves between the two participants. Its overall expression could be described as lively, agile, dynamic, and striving. Listening to it the second time and directing our attention to the lower voice of the metallophone, we might now hear a sudden change in dynamics (subito p), carried out by tone repetitions, leading into a pattern of interaction, out of which a clearly audible melodic theme evolves. The voice of the metallophone emerges out of the mutual play as leading voice.

Using the score of the patient’s and therapist’s voice we see precisely what is going on. Including the score we can see in Table 3 on page 13 how the perceived material has been structured into the descriptive musical and interpretative therapeutic language.

---

**Table 3:** Score of the patient’s and therapist’s voice

<table>
<thead>
<tr>
<th>LEVEL TWO</th>
<th>LEVEL THREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>descriptive</td>
<td>interpretative</td>
</tr>
<tr>
<td>Musical language</td>
<td>Therapeutic language</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basis of musical and extramusical Data.</th>
<th>Music Therapy Commentary</th>
<th>Personal remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>“What” and “How”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient</th>
<th>Therapist</th>
<th>Significant moments</th>
<th>Personal response</th>
</tr>
</thead>
<tbody>
<tr>
<td>M3 subito p: c2. Tone-repetitions in quavers</td>
<td>M3 second half of m.: imitative entry on lower fifth, taking over quaver chain. <strong>Imitating.</strong></td>
<td>Tonal orientation</td>
<td>The patient develops her inner expressiveness and agency, combined with the ability to articulate. She knows what she wants. Something makes her sure. She makes decisions. Agency, certainty and expressivity occur.</td>
</tr>
<tr>
<td>M4-8: responds to Therapist’s interruption è Interplay. Introducing tender accents, and expanding interval, intensifying expression. Developing theme From musical interplay: forte, accents.</td>
<td>Inserting quaver rests; interplay with binary quavers. <strong>Amplifying.</strong></td>
<td>Autonomous in dynamical shaping; uses dynamics as a turning point for a new musical expression and statement. Density of sound weave -&gt; close intra- and interpersonal relationship.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ascending quaver-Figure, blending the patient’s fourth-Motif. <strong>Connecting, supporting.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---
4.0 Conclusion

The activity of listening within the context of music therapy is a complex and personal matter. We may have experienced that it is not easy to differentiate one’s own thoughts when being emphatically involved in the event itself. How we as therapists experience the other person in the music is of paramount importance for the therapeutic course and success. According to place, time and situation our listening activity demands flexibility. Structuring listening activity prepares our thoughts and feelings for gaining the necessary consciousness to interpret what is being performed.

The following illustration Figure 2 on page 15 gives us a graphic summary of the cited modes of listening.
FIGURE 2. FCycle of Listening
Within the Cycle of listening we can move backwards and forward to re-check our different modes of listening. However, it may easily happen that our mind is fast working on the interpretative level, without re-checking the mode of Focussed Listening, on which the assessment of the basic material takes place. Therefore the Cycle of Listening can be viewed as an aid to discipline our therapeutic assessment and to elucidate the stages of interpretation as they move away from the experience itself.

Different modes of the listening activity are the process of making sense and lead us to new insight and knowledge. What we have realised silently within ourselves is made public and understandable for others through conveyance in words.

## 5.0 References


Evaluation of Music Therapy in German Neurorehabilitation -
Starting Point for European Comparability

Annkathrin Pöpel¹, Silke Jochims², Norbert van Kampen³, Holger Grehl⁴

¹ Dr. Annkathrin Pöpel
Klinik für Epileptologie
Uniklinik Bonn
Sigmund-Freud-Str. 25
53105 Bonn
0049-228-2875706 /7
e-mail: Annkathrin.Poepel@ukb.uni-bonn.de

² DRK-Therapiezentrum Middelburg
Middelburger Str. 1, 23701 Middelburg, Germany
Tel: 0049-4524-909145
Fax: 0049-4524-90949
e-mail: jochims-musik@gmx.de

³ Epilepsiezentrum Berlin, Ev. Krankenhaus Königin Elisabeth Herzberge
Herzbergstr. 79, 10362 Berlin, Germany
Tel: 0049-30-54723512
Fax: 0049-30-54723502
e-mail: n.kampen@keh-berlin.de

⁴ Ev. Krankenhaus Duisburg Nord, Abt. Neurologie,
Fahrner Straße 133, 47169 Duisburg, Germany
Tel: 0049-203-5081260
Fax: 0049-203-5081263
1.0 Abstract

In medicine there is a contemporary movement, which focuses on evidence-based medicine. This approach follows ideas of Archie Cochrane who has started to discuss outcome and effectiveness of medical studies and treatment. Practitioners should be sure about the appropriate evidence of chosen medication and methods to achieve evidence. Therefore the statistical tool of metaanalysis and systematic review methods of published studies was been developed further to compare studies with same methods, samples and outcome. This movement of medical research has become more and more an evaluation tool for the effectiveness of treatment methods and within the medical range. The article “Evaluation of Music Therapy in German Neurorehabilitation - Starting Point for European Comparability” from Annkathrin Pöpel, Silke Jochims, Norbert van Kampen, Holger Grehl is based on a talk given at the European Conference for Music Therapy in Naples, Italy in April 2001. They have done a literature review on music therapy in neurological rehabilitation. Read what they found out about the work being done in Europe.

2.0 Introduction:

Chairman, ladies and gentlemen, thank you for your invitation. I want to talk to you about music therapy in German neurorehabilitation and possible relevant aspects for European comparability.

Let me first introduce our group. Holger Grehl is senior consultant neurologist in the Hospital where I work. I am music therapist and doctor presently working at the Department of Neurology at a large Duisburg hospital. Several years ago I met Silke Jochims, a music therapist with many years of experience in neurorehabilitation. So last year we decided to conduct this study together and we asked Norbert van Kampen, sociologist at the Berlin Epilepsy Center and former colleague to help us with the statistics. We also enlisted the help of many others and I would especially like to thank Ann Duncan, Christa Fensky, Kristin Lamprecht, Elfie Landrock, Dorothee Nestor, Mareike Pöpel, Marie Luise Pöpel and Jan Weinhold.

Firstly I would like to give you a broad view of the relevant literature beginning with international publications and focusing on German publications. I will then talk
briefly about the principles of neurorehabilitation in Germany. Next, I will elaborate on the aims of our study, the methods and the preliminary results. At the moment the study is not yet finished but I think the results we already have show a clear tendency. Finally I will compare job reality with actual music therapy training courses in Germany and possible starting points for comparability with other European countries.

### 3.0 Literature

So, let me begin with the literature. In Medline one can find 890 publications using keyword music therapy.

**TABLE 1. Medline 2001**

<table>
<thead>
<tr>
<th>Keyword</th>
<th>counts</th>
</tr>
</thead>
<tbody>
<tr>
<td>music therapy</td>
<td>890</td>
</tr>
<tr>
<td>music therapy and neurorehabilitation</td>
<td>1</td>
</tr>
<tr>
<td>music therapy and coma</td>
<td>8</td>
</tr>
<tr>
<td>music therapy and stroke</td>
<td>10</td>
</tr>
<tr>
<td>music therapy and aphasia</td>
<td>15</td>
</tr>
<tr>
<td>music therapy and dementia</td>
<td>50</td>
</tr>
<tr>
<td>music therapy and Parkinson’s</td>
<td>8</td>
</tr>
<tr>
<td>music therapy and multiple sclerosis</td>
<td>2</td>
</tr>
<tr>
<td>music therapy and spinal injury</td>
<td>1</td>
</tr>
<tr>
<td>music therapy and pain</td>
<td>57</td>
</tr>
<tr>
<td>music therapy and epilepsy</td>
<td>1</td>
</tr>
</tbody>
</table>

If you continue in Medline using keyword - music therapy and German - you will find 137 publications.

**TABLE 2. Medline search**

<table>
<thead>
<tr>
<th>Keyword</th>
<th>Counts</th>
</tr>
</thead>
<tbody>
<tr>
<td>music therapy</td>
<td>890</td>
</tr>
<tr>
<td>music therapy and German</td>
<td>137</td>
</tr>
<tr>
<td>music therapy and German and coma</td>
<td>1</td>
</tr>
<tr>
<td>music therapy and German and stroke</td>
<td>1</td>
</tr>
<tr>
<td>music therapy and German and aphasia</td>
<td>4</td>
</tr>
<tr>
<td>music therapy and German and dementia</td>
<td>3</td>
</tr>
</tbody>
</table>
Regarding the chronology of German publications concerning neurorehabilitation there has been an enormous increase over the past thirty years. Between 1971 – 1980 there were 2 German publications on music therapy in neurorehabilitation. The first publication dates from 1977 and was written by Hermann Rauhe:

Rauhe, H.:
Antriebsförderung durch Musik: ein Ansatz zur rezeptiven Musiktherapie in der neurologischen Rehabilitation

Stimulation of drive by music:
Use of receptive music therapy in neurorehabilitation.
Journal: Die Therapie der Gegenwart

Left unmentioned until now are other publications which are not included in Medline, for example the German Journal for Music Therapy “Musiktherapeutische Umschau (MU)”. Last year MU marked its 20th anniversary with the publication of one volume on the development of music therapy in Germany in which 7 articles, written between 1980 – 2000 and considered important by the editors, are compiled including the article by Dagmar Gustorff: Lieder ohne Worte. Musiktherapie mit komatösen Patienten auf der Intensivstation (Songs without Words. Music therapy applied to coma patients in
intensive care units) first published in 1990. With the publication of this article the editors of MU intended to add a new dimension to music therapy in the medical field without a psychotherapeutic concept of music therapy in the true sense.

So one could view the nineties as the period during which German music therapists began to discover new working areas outwith the purely psychotherapeutic setting. At this point it slowly became clear that music therapy must no longer be viewed as simply a form of psychotherapy.

The intensive care unit is one part of rehab level A an B in the German neurorehabilitation system. In Germany neurorehabilitation is a relatively new and expanding field. 1992-1995 saw a 62% increase in the number of neurorehabilitation beds. In 1995 the German social insurances and the health administration developed the following concept of different categories in neurological rehabilitation and care:

**Concept Organising Neurorehabilitation in Germany**

A: acute medical treatment and care in intensive care units or normal clinical wards

B: early rehabilitation of patients being not really conscious and not co-operative and needing intermediate care services in cases of complications

C: rehabilitation of patients being conscious and able to cooperate but dependent upon care for ADL functions (activities of daily life)

D: rehabilitation of patients being independent in ADL functions but needing comprehensive treatment for further recovery

E: in- or outpatient rehabilitational aftercare for vocational and/or social reintegration

F: private or institutional care which must be aimed at maintaining the patients functional status

Which patients are treated in German neurorehabilitation hospitals?

There are 10 indication groups in German neurorehabilitation.

**Indication groups for Neurorehabilitation in Germany**

1. acute brain damage i.e. stroke, cerebral hypoxia, brain infection, brain tumor
2. chronic brain damage and degenerative processes i.e. cerebral palsy, Parkinson’s disease
3. multiple sclerosis
4. spinal injury
5. peripheral nervous damage caused by infection or injury
6. polyneuropathic syndrome
7. neuromuscular diseases and myopathic diseases
8. epilepsy
9. chronic pain syndrome
10. sequelae of nervous system injury

The main symptoms of these indicated diseases are disorders of vigilance and of motor function. There are some German publications on music therapy concerning these disorders but most, if you count those listed in Medline, focus on pain, aphasia and dementia. So we wanted to look at how is reality in German neurorehabilitation hospitals in practice? Do music therapists treat only patients with pain or dementia? How many hospitals offer music therapy? How are the working conditions for music therapists? In short terms our study aims to evaluate German neurorehabilitation hospitals and their therapeutic programmes concentrating especially on the integration of music therapy into the rehabilitation process as a starting point to compare the results with publications in other European countries.

4.0 Methods:

Based on a representative list out of - Fachhandbuch - Neurologische Rehabilitationseinrichtungen 1999, editors: Meier, U., Brosig, A., MediMedia, Neu-Isenburg, 1999 we evaluated 139 German neurorehabilitation hospitals. We developed two similar questionnaires, one for physicians and another for music therapists. All questionnaires were conducted by telephone. Both questionnaires had partly the same questions and partly different questions, in estimation concerning hospital structure, number of beds, rehab level, financing, staffing, number of music therapists, work environment, equipment, indication
criteria for music therapy, therapy intensity, frequency, outcome, professional qualification of music therapist, music therapy concept, music therapy integration and documentation. Data was collected and analysed using EXCEL and SPSS.

5.0 Results:

FIGURE 2. Slide 7

Music therapy is practised in 29% of all German neurorehabilitation hospitals in all categories of rehabilitation A, B, C, D, E, and F.
If you look at all hospitals, you will find most rehab beds on level B, C, and D with a maximum on level C. 85.2% of all hospitals offering music therapy have beds on level B, mostly patients with vigilance disorder, coma and so on. So we can see that music therapy is well represented in hospitals with rehab level B, in Germany referred to as early rehabilitation units.
70% of hospitals which do not offer music therapy show interest but lack the necessary funding. Only 3% are not acquainted with music therapy, 9% reject music therapy in neurorehabilitation and 5% think that music therapy is contraindicated in neurorehabilitation. On a purely medical level the interest is high and there is a broad acceptance of music therapy in neurorehabilitation. This is the potential we should use.

The next question looks at the working conditions of German music therapists in neurorehabilitation:
We questioned music therapists on these points. Most of them, 77.8% are employees and are integrated in another department. 78.9% have their own therapy room, CD-player or tapedeck and piano. Further provision varies: only half of all have their own office and VCR, 89.5% have other instruments than piano with a together worth between 10 000 and 250 000 DM.

Now let us have a look at the music therapy setting:
Nearly 90% of all music therapists offer one-to-one therapy. This is quite comprehensible in the case of coma patients for example. More astonishing is the fact that there is also a high percentage of group therapy offers. It is often the staff who prescribe music therapy and who set the therapeutic goals. Here the junior consultant takes second place in the decision making process. So it seems that the music therapist has very little say concerning the prescription and the therapeutic goals of music therapy.

Most therapists offer two sessions a week for one patient. The extent of treatment is nearly always combined with duration of hospitalisation.

All music therapists practice documentation.
FIGURE 7. Documentation in Music Therapy in German Neurorehabilitation

73.7% write hourly protocols, mostly individual and not standardised. 57.9% write a conclusion and in 36.8% this forms part of the medical conclusion.

It is well known that until now almost no defined indication criteria for music therapy exist. We asked music therapists and doctors in neurorehabilitation hospitals what they think the indication criteria should be.
We offered several options with a rating between 0 - no indication criteria - and 4 - absolute indication criteria. Here you can see music therapists viewpoint on indication criteria concerning sensory-motor deficits, vigilance and cognition disorder, autonomic dysfunction, communication initiation, the development of coping strategies, and the quality of life.
If you compare that to the medical viewpoint it looks very similar concerning this more common criteria for music therapy like establishing interaction and emotional stabilisation. Both groups view this and treating autonomous dysfunction for very important. But there is one clear difference: the medical viewpoint sees music therapy as more important to treat sensory-motor and cognitive deficit, the music therapists viewpoint favours other more common unspecific music therapy indication criteria like coping and quality of life.
I mentioned before that there is a broad acceptance on the medical side for music therapy in neurorehabilitation and this comparison of indication criteria adds another point we should be aware of: doctors believe in the use of music therapy more to treat specific neurologic deficits like sensory-motor function deficits or cognitive deficits than music therapists. Probably music therapy training programs influence the music therapists viewpoint. I will discuss this later.
We then went on to ask about specific skills music therapists in neurorehabilitation should have in the following three fields:

1. Neurology,
2. Psychotherapy,
3. Music

![Bar chart showing special skills of music therapists in neurorehabilitation.](chart)

Music therapists had to give their ratings again. 0 means this skill is absolutely unimportant, 4 - this skill is absolute important. In simple terms you can see music thera-
pist regard all aspects as being very important, psychotherapy being the most important of all. The neurological aspect seems of less importance. The medical viewpoint shows:

**FIGURE 11. Special Skill of Music Therapists in Neurorehabilitation – Medical Viewpoint**

Psychotherapy is not the most important thing, 35 % think analytical psychotherapy is really unimportant. But on the other hand 30% think it is very important. But if we compare music therapists and medical viewpoint on special skills we can see there is no real difference.
Regarding the standards of music therapists qualification in neurorehabilitation in Germany I think they are comparable high.
84% of all German music therapists in neurorehabilitation are trained, 52.6% holding a state registered diploma. Level of certification vary between master (university), bachelor degree (Fachhochschule) and others (Fachschulabschluß) comparable to college.
6.0 Conclusion

One can find music therapy as a supplementary offer in German neurorehabilitation hospitals in all rehabilitation units and in hospitals treating a variety of neurological deficit disorders such as deficits in vigilance, cognition and the sensory-motor system. Most hospitals with early rehabilitation units, rehab level B offer music therapy. So mostly patients with vigilance disturbance are treated with music therapy. German literature provides only single case studies and non quantitative reports on music therapy in neurorehabilitation. The use of music therapy in German neurorehabilitation is not standardised and therapy concepts vary. There are no established standards for documentation, evaluation and outcome measurement.

The education level of music therapists vary from university level (MA), Fachhochschullevel (BA) to private education. I think it is very important to look shortly at German music therapy training system concerning neurorehabilitation. We asked all German music therapy training institutes if they offer special courses for music therapy in neurology and neurorehabilitation on their curriculum. Here are the results:
Only 30% of all music therapy training institutes integrate this topic on their curriculum. If we differentiate regarding the education level, one can clearly state that the highest level has the poorest offer.
One can assume that the German music therapist training neglects this area somewhat. It would be interesting to compare these results with music therapy training in other European countries.

Further evaluation should compare the evaluation of hospitals in other European countries, integrate European publications and develop a transparent and comparable study design to show a clear indication for music therapy in neurorehabilitation.

Let me close with one remark: in November 2000 the Neuro Rehab meeting 2000 took place in Berlin with an international forum on neurological rehabilitation concerning two main topics:

- recent investigation into use-dependent structural changes in CNS
- evaluation of rehabilitation therapy strategies which match the criteria of evidence based medicine.

Evidence based medicine is the conscientious, explicit and judicious use of currently best findings in order to make the best decisions about the care of individual patients.

Rhythmic acoustic stimulation has been presented as an evidence based method of music therapy in neurorehabilitation. RAS is one method of neurologic music therapy.

Table 4: German Music Therapy Training – Special Courses in Neurorehabilitation (NR)

<table>
<thead>
<tr>
<th>level</th>
<th>number</th>
<th>NR yes</th>
<th>NR no</th>
<th>Similar contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>University ~ M.A.</td>
<td>7</td>
<td>0</td>
<td>6</td>
<td>- general medicine, - physiology, - pain, - medical-psycho.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0%</td>
<td>100%</td>
<td>- psychological basics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 missing value</td>
</tr>
<tr>
<td>Fachhochschule ~ B.A.</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>- general medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>others</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>- general medicine, - sensoryphysiology - pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>56%</td>
<td>44%</td>
<td>2 missing value</td>
</tr>
</tbody>
</table>
developed by Michael Thaut. Despite all evidence to the contrary, the German health authorities unjustly list music therapy as non-scientifically based and health insurers, therefore, refuse to pay for this benefit. In conclusion, Ladies and Gentlemen: I advocate the implementation of evidence based music therapy in neurology and neurorehabilitation. Thank you very much for your attention.

7.0 Literature:

Fachhandbuch - Neurologische Rehabilitationseinrichtungen, Hrsg.: Meier, U., Brosig, A., MediMedia, Neu-Isenburg, 1999


1.0 ABSTRACT

This article focuses on research into Alzheimer’s disease and music therapy. It shows that music therapy investigations are possible with Alzheimer patients even in an advantage state when therapy stimulates emotional and sensory areas. 15 patients were treated and three areas of cognitive, emotional and sensory/physical developments were assessed over the course of one year. Because Alzheimer is a degenerative disease, the purpose of Music Therapy cannot be to cure the patient, but to offer the possibility to interact with the outside world. Music therapy offers a valuable tool to assess residual, potential and expressive abilities of patients. Even more it is a communicative tool to build up new structures which can open up new means of communication and interaction with reality. While cognitive tests focus on cognitive abilities, music therapy treatment should focus on emotional and sensory abilities. This can result in the enhancement of cognitive processes.
2.0 THE SUBJECTS

This research is still going on, therefore, we are presenting the partial results which we have reached during the course of one year while treating 15 Alzheimer patients.

They have been observed in the following institutions: “Istituti Riuniti Airoldi e Muzzi” in Lecco and “Centro Diurno Integrato, Casa Prina” in Erba.

We selected 5 patients in the middle and/or advanced stage of the disease, all of them at the sixth functional stage according to “The Global Deterioration Scale” or GDS (B.Reisberg, T.H.Ferris, T.Crook, 1982) and at the third score of the “Clinical Dementia Rating Scale” or CDR (Hughes et al; Heyman et al, 1987)

The CDR provides caregivers an overview of stages of cognitive function for those suffering from a primary degenerative dementia such as Alzheimer’s disease.

Impairment levels are determined in six cognitive - functional categories (see Table 1 on page 2)

<table>
<thead>
<tr>
<th>Impairment Level and CDR Score (0, 0.5, 1, 2, 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None 0</td>
</tr>
<tr>
<td>Memory</td>
</tr>
<tr>
<td>Orientation</td>
</tr>
<tr>
<td>Judgment &amp; Problem Solving</td>
</tr>
</tbody>
</table>

TABLE 1. CLINICAL DEMENTIA RATING (CDR)
3.0 AIMS OF THE RESEARCH

Verify the validity of an observation method in order to:

- Investigate how to open new communication channels and find new ways of interaction with reality by using music therapy.
- Verify the validity of music therapy with Alzheimer patients in the middle and advanced stage of the disease.

4.0 THE MEANS OF THE INVESTIGATION

4.1 The Observation

The research entails the analysis of processes taking place during a set period of time within a general project, the aims of which have been mentioned above (See “AIMS OF THE RESEARCH” on page 3).

The observation, based on the psycho-dynamic approach, has been logged in the form of “observation records” during the ten months of treatment.

This observation method requires the video and audio recording of each session in order to collect the data and complete the observation sheet.

<table>
<thead>
<tr>
<th>Community Affairs</th>
<th>Independent function at usual level in job, shopping, volunteer and social groups</th>
<th>Slight impairment in these activities</th>
<th>Unable to function independently at these activities although may still be engaged in some; appears normal to casual inspection</th>
<th>No pretense of independent function outside home; Appears well enough to be taken to functions outside a family home</th>
<th>No pretense of independent function outside home; Appears too ill to be taken to functions outside a family home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Hobbies</td>
<td>Life at home, hobbies, and intellectual interests well maintained</td>
<td>Life at home, hobbies, and intellectual interests slightly impaired</td>
<td>Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned</td>
<td>Only simple chores preserved; very restricted interests, poorly maintained</td>
<td>No significant function in home</td>
</tr>
<tr>
<td>Personal Care</td>
<td>Fully capable of self-care</td>
<td>Needs prompting</td>
<td>Requires assistance in dressing, hygiene, keeping of personal effects</td>
<td>Requires much help with personal care; frequent incontinence</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 1. CLINICAL DEMENTIA RATING (CDR)
The videos are considered most important for the supervision of the team work.

### 4.2 OBSERVATION FIELD

#### 4.2.1 The sound and musical element

We have explored the sound and musical expression as our field of observation.

The sessions included:
- Individual treatment
- Treatment 2 or 3 times a week
- Use of musical instruments and Hi Fi

The sound and musical element has been considered and analysed according to its primary qualities and linked, first with the sensory qualities (such as: light/dark, smooth/rough, sweet/bitter, etc…), and then with the emotional categories. We have observed and assessed the patient through:
- The quality and the form of his responses within the “sound interaction”
- The quality and the form of his psychomotor responses to the listening of the music.

![FIGURE 1. AREAS OF OBSERVATION](image)

#### 4.3 AREAS OF OBSERVATION

The observations have been analysed, first by dividing and then assembling the events which have enabled us to define a unit or a specific area of observation. They have been defined and described in order to be recognised and identified in the whole behavioural stream of the human being.
Music Therapy Today (online), August, available at [http://musictherapyworld.net](http://musictherapyworld.net)

We have then defined the various behaviours under specific categories by using the data collected (written and video recorded materials).

By using a chart made up of behavioural categories we have been able to change a description of an event into an assessable event.

Through this method it has been possible to assess the behaviour of the patient and compare it to that of another patient.

We have chosen this chart because it defines the AREAS and CATEGORIES which can describe the complexity of the human being.

TABLE 2. Areas and Categories

<table>
<thead>
<tr>
<th>AREAS</th>
<th>CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>COGNITIVE</td>
<td>Attention, Cognitive responses</td>
</tr>
<tr>
<td>EMOTIONAL</td>
<td>Emotional involvement, Emotional responses</td>
</tr>
<tr>
<td>SENSORY AND PHYSICAL</td>
<td>Posture, Sensory responses</td>
</tr>
</tbody>
</table>

As to the **cognitive area** we have considered the following **categories**: the **attention** seen as the main function of the mind which implies all the cognitive activity and the **cognitive responses** which comprise judgement, consideration, memory, recognition that the patient still maintains.

As to the **emotional area** we have considered the following **categories**: emotional participation, and emotional responses.

As to the **sensory and physical area** we have considered the following **categories**: the **posture** and the **sensory responses** (sight, hearing, touch, smell, taste).

The relationship occurred mainly through the emotional and sensory areas as they are the means by which it is possible to recover compromised functions and abilities and stimulate the hidden ones, or the ones which are fading away. The sound served to build up a relationship as it is the protagonist and means of the relationship itself.

**4.4 ASSESSMENT AND INTERPRETATION OF THE DATA**

The data concerning each area have been put into two **SUB – CATEGORIES**: 
• **THE STATE (global response)**: this means that the patient remains aware during the session because attention, emotional participation and posture are visually active for most of the time.

• **THE BEHAVIOURS (exceptional responses)**: this means that the patient is active when he shows cognitive, emotional and sensory responses only occasionally i.e. at a given time.

### Table 3:

<table>
<thead>
<tr>
<th>AREAS</th>
<th>STATE</th>
<th>BEHAVIOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COGNITIVE</td>
<td>Attention</td>
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<td>SENSORY AND PHYSICAL</td>
<td>Posture</td>
<td>Sensory responses</td>
</tr>
</tbody>
</table>

The following indicators show the responses over time for the two sub – categories:

0= no response

1= rare

2= discontinuous

3= fairly continuous

4= continuous

Each category has been given a specific score and the mean value obtained by the two sub – categories represents the AREA SCORE.

### 5.0 RESULTS

**FIGURE 2. Patient MR**

FIGURE 3. Patient FP

FIGURE 4. Patient TP

FIGURE 5. Patient CG

FIGURE 6. Patient GM
Some considerations arise from the analyses of the data which are shown in the graphs.

First of all we must highlight the importance of the responses obtained in the emotional and sensory areas, which show their crucial role in maintaining, or recovering the channel of communication and expression even in the advanced stage of the disease.

In particular the graphs referring to T.P (Figure 4 on page 7) and G.M (Figure 6 on page 7) patients prove the former statement. In these graphs the cognitive area is decreasing while the emotional and sensory areas are increasing.

The graphs of M.R. (Figure 2 on page 6) and F.P (Figure 3 on page 7) show the responses of all the areas in the initial phase followed by an increasing decline due to the aggravation of the Alzheimer’s disease. As a matter of fact since the beginning of the treatment, both advanced stage patients showed the following symptoms: severe aphasia, difficulties in deambulation, rigidity, etc…

The graph of C.G (Figure 5 on page 7) shows the sudden aggravation of the general health conditions even though he had started the therapy in an earlier degenerative stage.

FIGURE 7. All patients after 10 month

FIGURE 8. All patients after 10 month
These observations enable us to make two important statements:

1. A music therapy treatment with an Alzheimer patient in an advanced stage is possible when the therapy stimulates the emotional and sensory areas. All the graphs actually show that these are the areas most involved.

2. The goals of music therapy cannot be complete recovery of patients, since the disease is degenerative. The purpose of music therapy is to give the patients the possibility to interact with the outside world, even in an advanced stage.

In addition to statistical analysis of the data, we have to analyse the data from a qualitative point of view.

The results can be read from two points of view: on one hand the data can be useful for the general comprehension of the pathology and for the outline of the possible curative strategies; on the other hand the data can be an additional step forward in the music therapy research.

5.1 General results:

- The responses obtained in all the areas prove that it is possible to treat patients in an advanced stage.

- This observation method offers a new way to assess the residual and potential abilities of the patients who cannot be tested using existing tests such as Mini Mental State of Folstein.

- The sensory and emotional areas can be considered as the field where the personality of the patient can still manifest and express itself and also are the starting point for building up new structures which can open up new means of communication and interaction with reality.

- The response to the music therapy treatment has been considered as extraordinary by the medical team in spite of the poor health conditions of the patients.
5.2 Specific results

- In order to adopt efficient music therapeutic strategies, it is necessary to have an individual treatment and an initial careful observation of the three areas.

- The interaction with the “sound”, as the means of the therapeutic relationship, is possible only through the activation and the observation of the sensory and emotional areas.

- The knowledge of the personality of the patient and the relationship with it, has been possible through the interaction between the emotional experiences and the sound element. The question/answer game has been the modality by which the relationship could develop.

- The opening of new communication channels could be achieved thanks to the stimulation of the sensory and emotional areas through the careful use of the elements of the sound.

6.0 DISCUSSION

In this research we have given the most important role to the emotional and sensory areas, as these are the starting point from where a relationship can arise and be the means through which the functions and abilities can be reactivated in order to get the patient to communicate.

The results of our work have highlighted the capacity of the body to express the memory of its own experiences. The patient was able to express his feelings and inner life through the synesthetic qualities of the sound used in the production and listening modalities.

We have also noticed that the activation of the sensory and emotional areas of the patient enabled him to exploit the cognitive area. The results obtained through the observation of the cognitive area, which is usually silent in these patients, have been considered as extraordinary.

In conclusion we can say that this observation becomes the main, but not the only instrument, to reach, understand and communicate with the Alzheimer patient.

This method helps the operator to know, welcome, take care of and respect the needs of these human beings.

7.0 BIBLIOGRAPHY


PLACES TO LEARN - A CONTEMPORARY DEMAND FOR STUDENT PLACEMENTS IN MUSIC THERAPY

Simon Gilbertson

1 Chair for Qualitative Research in Medicine, University Witten Herdecke
I would like to thank Prof. Dr. med. W. Ischebeck, Klinik Holthausen for the friendly support that made this work possible.

1.0 Abstract

Internships must be offered in all areas of clinical application. Their role in the development of future therapists is multi-faceted. Therapists with experience in a wide range of areas of clinical applications can most optimally provide for the needs of patients.

Employment opportunities exist in neurological rehabilitation and it is our responsibility to assist in training students to fill these positions before the positions disappear due to a shortage of therapists.

Most importantly, internships play an essential role in developing a solid infrastructure from which the quality of patient care can immensely profit.

2.0 Introduction

Initial work carried out by pioneering therapists working in the field of neurological rehabilitation now demands the development of a supportive infrastructure from within the profession of music therapy.

The three main cornerstones of our profession are education, practice and research. Attending to the needs of students is a responsibility which should be carried by all three areas.

Pioneering therapists have started working with clients with illnesses who had previously not been offered music therapy (Gilbertson 1999). Adaptations to therapy models were
made in new clinical settings and these changes must be continually communicated to
education institutions. A research tradition is developing (Aldridge 1996) and contempor-
ary research projects focus upon the wide range of new areas of clinical application
(Magee 1998).

This paper is a call for attention to one of the important elements in the development of the
profession: internships. The area of neurosurgical rehabilitation will be used to demon-
strate my reasoning behind my appeal for your attention upon this important element of
our profession.

3.0 Internships

3.1 Contact with individuals with neurological illness

Music therapy students should have the opportunity to have contact with individuals liv-
ing with the challenges of neurological illness. Within the field of neurosurgical rehabilita-
tion patients present a very wide range of medical conditions.

Examples of primary illnesses in neurosurgical rehabilitation include:

- Malformation of the central and peripheral nervous systems, benign and malignant neo-
  plasm (tumour) in the brain, spinal cord and peripheral nervous systems, traumatic
  brain injury (TBI), vascular malformation, vascular insult, vascular haemorrhage and
  conditions following vascular surgery.

Due to morphological changes in the brain almost all aspects of life can be affected. The
major functional disorders include:

- Motor dysfunction (plegia, paresis, ataxia, apraxia), Speech/Language disorder (apha-
  sia, dysarthria, aphonia, dysphonia), neuropsychological function disorders of memory,
  concentration, awareness, cognitive processing, affect, perception and changes in per-
  sonality.

To date, relatively few therapists, educators and researchers have come into contact with
individuals dealing with the challenges of these forms of illness at the time of onset and
thus it is important that students have the opportunity to gain experiences at this phase of
the therapeutic process.

3.2 Time for literature and listening

At the present stage of development educators cannot cover all the areas of clinical appli-
cation. Internships offer assistance to training courses in opening new fields of experience.
Interns should be offered time for learning from the basic literature concerning neurology,
neuroanatomy and neuromusicology. This allows the students also to learn about their
own musical functioning and understand basic processes in musical ability. Time should
be offered to spend with patients, to learn how to listen and to hear how these individuals understand their own challenges.

3.3 Dealing with initial reactions towards severely injured patients

As there is only a relatively small amount of film material of neurorehabilitation in circulation, interns are confronted with their initial reactions to patients who have recently experienced neurological trauma. Attitudes towards patients may not change (Asmus 1985) but students should have the opportunity to acclimatise themselves within their new environments. Many patients requiring neurosurgical treatment have been involved in dramatic incidents such as traffic accidents and can have severe multiple injuries to all parts of their bodies. Their appearance can be dramatically altered particularly following head/face injuries.

“Sometimes it seemed like I was in a freak-show. Mostly after a short period of reflection I could find an explanation for the phenomena, but was impressed by the diverse appearances and the near to grotesque severity. (…) And the first patient, almost half of her skull was missing, the skin sinking inwards, made a vivid remaining impression upon me.” (J.Z., Intern)

3.4 Contact with various forms of music therapy

An internship can offer the student the opportunity to come into contact with forms of music therapy that differ from those taught in their own training course.

“The most central experience for me in my practicum was the work in individual and group therapy which differed from that which I had learnt to date. (…) The work with these patients demanded a rethinking about the role of the music in this form of music therapy.” (J.R., Intern)

3.5 Seeing individual variations of music therapy

If the internship takes place in an institution where a team of music therapists are working then the student has an opportunity to see how individual characteristics within a form of music therapy can be developed.

“My work in the music therapy team was mainly concentrated on the work together with my mentor and conversations with the other music therapists in the team. Thereby it was interesting for me to see and get to know differing understandings of the role and aims of music therapy in neurosurgical rehabilitation because they have helped me to sharpen my viewpoint of what music therapy can
offer in this area within the context of my own practical work.”
(J.R., Intern)

3.6 Experiencing a wide range of professions

Due to the fact that neurological illness can lead to the development of a multiple symptom complex most modern rehabilitation institutions offer a wide range of therapies. Thus an intern has an optimal setting to learn both the roles of various therapy forms and to experience multi-disciplinary communication and shared clinical language. A modern rehabilitation institution should offer the following forms of therapy:

- art therapy, medical care, neuropsychology, nursing therapy, music therapy, occupational therapy, physiotherapy, psychotherapy, social work, speech/language therapy.

3.7 Developing individual ability based on clinical relevance and self-motivation

Many skills required from a student do not reach maturity during the training course. Here the pressures of being a successful candidate, obtaining a qualification and teacher-student relationship can blur an objective impression of needy areas. The internship offers the student a further opportunity to challenge their abilities, to be driven by self-motivation, and not to be distracted by the “risk” of deficits becoming transparent at the training institution. It has become clear that students perceive their real abilities and deficits in a clinical setting well. Basic aural skills, improvisational skills and instrumental knowledge are the most common areas that are most in need of development.

3.8 Future benefit for “ex-interns”

Even if students do not chose to work as qualified therapists in the area of their internship, their experience and knowledge will enhance the quality of their later work as therapists. The information gathered about the brain and its functions, both musical and non-musical, will assist them in making qualified, well-reflected clinical interpretations. Furthermore, the new therapist will be able to make better recommendations in referral situations.

3.9 Learning about early stages of patient care following neurosurgical treatment

Particularly in early neurosurgical/neurological rehabilitation clinics students have the opportunity to come into contact with a wide range of patients who one may meet at later stages of treatment or continuing care.
After leaving early rehabilitation clinics the patients are referred to a wide range of institutions such as in the areas of psychiatry, day centres, residential health care institutions or in palliative care. Knowing a little more about where a patient is coming from, how their medical biography may be affecting their actual health situation can raise the quality of continuing therapeutic care.

4.0 Summary

Internships must be offered in all areas of clinical application. Their role in the development of future therapists is multi-faceted. Therapists with experience in a wide range of areas of clinical applications can most optimally provide for the needs of patients.

Employment opportunities exist in neurological rehabilitation and it is our responsibility to assist in training students to fill these positions before the positions disappear due to a shortage of therapists.

Most importantly, internships play an essential role in developing a solid infrastructure from which the quality of patient care can immensely profit.

5.0 Literature


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The Role of Music in the Rehabilitation of Persons with Neurologic Diseases: Gaining Access to ‘Lost Memory’ and Preserved Function Through Music Therapy

Concetta M. Tomaino

D.A., MT-BC Director, The Institute for Music and Neurologic Function, Vice President for Music Therapy at Beth Abraham Health Services
612 Allerton Avenue
Bronx, New York 10467 USA
(718) 519-4236
ctomaino@bethabe.org
http://www.musichaspower.org

1.0 Abstract

The music therapist must have an understanding of the various disease and neurological processes to adequately assess functional ability and plan appropriate use of music for the course of treatment. We have memories for not only the particulars of a song, such as the melody or lyrics, but also the rich associations that keep the melodies alive for us throughout our life. Memories are not actually lost with dementia or with other brain injuries; rather, the ability to retrieve and gain access to these is damaged. As we possess memories for factual information, we also possess memories or ‘motor templates’ for physical movements. Through music therapy, we have the ability to help patients reintegrate the sense of movement that they have lost. Despite the increased acceptance and understanding of the therapeutic benefits of music therapy in work with persons with neurologic impairments and challenges, more research needs to done to demonstrate its efficacy in application with a wide range of diagnosis.

2.0 The role of music ...

Music therapists working with persons with neurologic diseases, including multi-infarct dementia or Alzheimer’s disease, have observed for years the dramatic responses that
occur when familiar music is presented to these individuals. Attention is maintained, fragments of memories unfold, and a true connection to the self takes place. Even with a specific diagnosis, the range of abilities and disabilities related to a neurological disease can vary greatly with each individual. The music therapist must have an understanding of the various disease and neurological processes to adequately assess functional ability and plan appropriate use of music for the course of treatment.

The medical needs of neurologic patients appropriate for referral to music therapy include: memory deficits, depression, balance/gait problems, fine motor problems, agitation/aggressive behaviors, acute or chronic pain, poor attention, decreased vocal projection, expressive aphasia, poor motivation, reduced muscle strength, Alzheimer's disease, multiple sclerosis, Parkinson's disease, and stroke. The use of music as a therapeutic tool for persons with neurologic disease has tremendous potential because of the many ways the individual properties of music i.e., rhythm, melody, and harmony, induce sometimes predictable neurologic responses. Some examples of this are auditory cueing for gait (Thaut & McIntosh, 1992), and the use of music as a retrieval mechanism for those with memory impairment (Tomaino, 1998).

Of the elements of music the two which have the most immediate effects on function are, rhythm and melody (by melody I am referring to the power of a familiar melody to trigger emotional responses and long-term memory retrieval) Various rhythmic stimuli can trigger motor function and help in initiation in persons with stroke and Parkinson's disease. In the book Music and the Brain, by Critchley and Henson (1977), N. Wertheim states: "There is no meaning to a rhythm without a message and the impact upon the listener depends on this message carried by the rhythm, or else lent to it by the listener himself. We know that this particular area of the brain stem, the reticular system, is concerned with a regulation of the cortical electrical rhythms...there are abundant connections between the reticular formation and the auditory pathways. It may be that the rhythmical component of the auditory input has an impact on the whole cerebral cortex and also on large subcortical areas, via the extensive connections of the reticular formation with all these regions.

People's experience with music throughout their lives can influence how they will respond to rhythm and sounds presented during therapy sessions. At times rhythmic cueing can be as simple as a metronomic beat but at other times a person may be more responsive to the more complex rhythms of African drumming. This indicates that rhythmical processing may serve to cue attention as well as initiation, however more research needs to be done to understand how complex rhythms are processed by the cortex as well as subcortical regions. There is a strong connection between the auditory system and the limbic system. This biological link makes it possible for sound to be processed almost immediately by the areas of the brain that are associated with long-term memory and the emotions (Tomaino, 1993). Because processing occurs and/or is mediated at a subcortical level, some information processing is possible despite higher cortical damage. This is evidenced clinically by the strong emotional responses to familiar music we observe in person in

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persons with memory deficits, such as traumatic brain injury, multi-infarct dementia or Alzheimer's disease. Familiar songs become a tool for connecting to seemingly lost parts of the personality by providing a necessary link to the "self".

We have memories for not only the particulars of a song, such as the melody or lyrics, but also the rich associations that keep the melodies alive for us throughout our life. Memories are not actually lost with dementia or with other brain injuries; rather, the ability to retrieve and gain access to these is damaged. Music, then, can provide access not only to specific moods and memories, but also to the entire thought-structure and personality of the past. In a clinical study (Tomaino, 1998), when personally preferred music was presented to persons with medium to late stage Alzheimer’s Disease, each participant demonstrated the ability to spontaneously verbalize fragmented information about their past. One of the participants, Molly, who was non-verbal at the beginning of the music therapy intervention, began to speak after hearing an Irish tune repeated for the third time. Although she only stated “That’s nice”. It was the first coherent remark she had made. At that point the therapist asked Molly where she was from and she replied from Ireland and then continued to talk about her family and what a nice town it was. Even though the phrases were fragmented the images and ideas Molly was trying to present were clearly connected.

As we possess memories for factual information, we also possess memories or "motor templates" for physical movements. Many adults are institutionalized following a stroke that leaves them with a weakness or paralysis on one side of the body. Even persons with dementia may lose the ability to initiate movements. By stimulating a similar but neurologically different physical activity, music, with a strong rhythmic base, can allow for spontaneous movement, thus keeping limbs and joints free from possible atrophy and contractures. Music, and in particular rhythm, can play a essential role in treatment by providing the necessary cues to reintegrate the sense of movement. The loss of neurologic function can trigger the activation of compensatory mechanisms, which have been lying dormant within the brain, to partially or completely ‘take over’ the absent function. This phenomenon is known as ‘neural plasticity’. There are many alternate nerve pathways and connections that can be used to re-establish behaviors. Damasio (1994) indicated that neurologic function includes the recruitment of certain neural pathways, depending on the type of stimulus or the subsequent response. In persons with hemiparesis (a weakening of one side of the body) it may be possible to stimulate alternate motor pathways with the "right" music/rhythm. For example, walking and dancing, though both physical movements, use different postural schema. Through music therapy, we have the ability to help patients reintegrate the sense of movement that they have lost. The following clinical example illustrates this point:

Sam was a man in his late 60’s recovering from a recent stroke. He was on physical therapy and was considered a guarded walker --he could walk independently with a quad cane. The discharge team was concerned that Sam’s uneven gait might cause him to
stumble if he walked on an uneven surface like a typical concrete pavement. His was referred to music therapy in hopes that he could improve his proprioception and regain his ability to lift both legs enough to manage the challenges of walking out-of-doors. Sam was able to communicate well and provided information about his past experiences with music including how, as a teenager, he used to go dancing every week. However, he had not danced in over 40 years. The physical therapist tested Sam’s gait and I found some music with a tempo that matched the pace of his stride. The music was familiar to him and he felt comfortable walking to the tempo. As he became more confident of his movements, he began to add dance steps, sliding his feet or clicking his heels. As the sessions progressed, he became more inventive in his movements and within several weeks, of meeting two times a week, he began to lift his left foot off the floor. He was not aware of this but stated that he was able to feel the tempo in his leg and thought that he was able to actually feel the floor with his left foot. Previously he had mentioned that one of the most frustrating things for him was to go to the entertainment programs here and have his right foot tap away, while his left foot remained immobile. He was regaining sensation in that side. We worked together, twice a week for two months. At the same time he continued in physical therapy where the therapist used Sam’s internal memory of the music to cue his gait. Sam was soon discharged and moved to an apartment in the community.

Despite the increased acceptance and understanding of the therapeutic benefits of music therapy in work with persons with neurologic impairments and challenges, more research needs to done to demonstrate it’s efficacy in application with a wide range of diagnosis. Clinical research in parallel with basic scientific studies which investigate the underlying neural mechanisms stimulated by components of music must continue so that a new understanding of music and the brain will emerge. This knowledge may influence how music can best be applied therapeutically. As technology advances, especially in the area of neuro-imaging, and as clinical research continues, we will be able to fully understand the multiple processes of memory, the complexity of neural networks, and mostly, how music connects to essential neurologic function.

3.0 References:


WHEN THE PRESENT HAS BECOME A MERE STAGE FOR THE PAST - MUSIC THERAPY IN THE CASE OF A PATIENT WITH EXTREME DEMENTIA

Barbara Dehm-Gauwerky

1.0 Abstract

This article presents and reflects the music therapy session with an Alzheimer patient. The reflection is theoretically based on psychoanalysis. By understanding the actual interaction as transference of early childhood patterns emotional experiences of being held become possible. In this process the quotation of old church songs reflects and comments the actual situation. Faced with death thus spiritual issues were evoked and music therapy can help for a peaceful dying-process.

2.0 Introduction

To prepare you a little for this topic, I’d like to ask you to imagine the following situation:

You arrive in a country that is totally unfamiliar to you. You don’t know where you are, and can’t even say who you are and what your name is. It’s been like that for a long time, but you don’t know how long. You’ve lost all sense of time. The question of what day it is, or what time has become meaningless. You’re tired and exhausted, your legs shake. Sometimes you have the feeling you’ve nothing under your feet, other times the ground feels more solid. You wander about aimlessly, and perhaps you feel panic or fear.
This, or something similar to this, is the way a person with advanced Alzheimer’s disease or multiple infarct dementia can experience the world. These forms of dementia are characterised by a progressive, irreversible process of brain deterioration that finally ends in death. In addition to problems with speech and movement, sufferers experience increasing loss of memory and of orientation in time and space. Ego functions deteriorate to the point of complete disorganisation. I therefore regard people with dementia as people who are dying. People in this situation seem no longer to perceive an external reality that gives them their bearings. We encounter people who sometimes behave like infants and can’t depart from established patterns of interaction.

What can help in cases like these?

I should like to demonstrate to you how music therapy can bring about understanding and thus relief by giving you a short description of one case.

By music therapy I mean a special form of psychoanalytic psychotherapy that is concerned with naming the interaction between transference and countertransference. A. Lorenzer (1973) calls this “scenic understanding”; and, as we know, Freud was of the opinion that understanding has a healing effect. “Scenic understanding” denotes a process of symbol creation for which there are three levels available to us: That of language, that of music, and that of concrete actions. Music in the form of free improvisation and quotations of songs has a specific function in this process because of its intermediate position as sensual-symbolic form of interaction. This concept makes the meaning of transitional objects and phenomena comprehensible in Lorenzer’s theory of socialisation.

3.0 Story of Mr. K.

Now let me begin the story of Mr. K.

Mr. K. was a strongly-built eighty-year-old man who suffered from a multiple infarct dementia. He had been a patient in a closed geronto-psychiatric ward for several days. He was in a wheelchair, because he could barely walk anymore. He didn’t speak, and cried out loudly in a pitiful manner at regular intervals – especially when others were sleeping.
I got to know him during two short episodes.

At the time, I was holding a singing session in this ward once a week. It was open to all patients. As with most of them, I didn’t have Mr. K.’s case history at my disposal, let alone any knowledge about his life story. A ritual had developed for the group singing session: at the beginning and end of the session, the same opening or closing song was sung. After the opening song, I used to greet every patient personally by name. Then we started with the singing. I always left the choice of song up to the old people. If for any reason no request for a song could be made, I named songs that seemed to me to fit the mood of the group, or themes that had already been touched upon. This is exactly what occurred during the session that Mr. K. attended.

1st Episode:

Mr. K. was rather restless sitting in his wheelchair, but didn’t cry out. Instead, he listened to the others singing. Towards the end of the session, the song “Do You Know How Many Tiny Stars There Are?” was requested. After only a few notes, Mr. K. began to weep in a heart-rending fashion. I felt very sorry for him, and would have liked to comfort him. But I had to look after the rest of the group as well, which had become restless. So I could only say a few friendly words, and ask the trainee who was present to go and sit next to him. After the session Mr. K. was still weeping and now, I was sitting too by the other side of him. With us two women on either side his tears subsided. A very kind, motherly nurse had seen what had happened, and came over. She gave Mr. K. a hug and took over from us music therapists.

Shortly afterwards, I met one of Mr. K.’s family by chance: I was just about to leave the ward when his daughter was let in. She told me in passing that, since his illness, Mr. K. had been looked after by her and his sister-in-law at home. She also told me that his wife, from whom he had been divorced, had died long ago. She said that, up to now, taking care of him had been no problem. Only his increasing confusion and disturbed periods had
made a stay in hospital necessary. Mr. K. would continue to be looked after at home afterwards.

2nd Episode:

The following day, I arrived in the ward around midday. I heard Mr. K. yelling when I was still some distance away. Most of the patients were resting or sleeping. Mr. K. had been brought into the day room, in which the singing session had taken place, so that he wouldn’t startle all the other patients out of their sleep. I felt very sorry for him again, so I went over and sat down next to him as I had done during the singing session. The song “How Beautifully Shines the Morning Star” spontaneously came to my mind. I sang it softly to myself. Mr. K. very quickly became quiet and fell asleep.

The nurses on duty were very pleased and joked about this dramatic change.

4.0 Questions and reflections

These scenes raise some questions:

Why did Mr. K. cry out so piteously? Why did he weep when he heard the song about the tiny stars? Why did he calm down when the trainee and I sat next to him? Why did he stop his yelling and fall asleep when I sang the song about the Morning Star?

We can only find an answer to these questions if we see everything that happened here as transference. A. Lorenzer calls transference the repetition of childhood patterns of experience. Freud, in his essay “Beyond the Pleasure Principle” (1920), even speaks of repetition compulsion. He cites children’s games as an example, taking his grandson’s cotton-reel game to illustrate his point. Freud sees repetition compulsion as a manifestation of the death instinct. This means, however, that Mr. K. was no longer completely “of this world”. In his state of complete disorientation, outer reality no longer existed for him as an order-
ing principle. He therefore reacted to everything that happened according to established patterns of interaction. I see it as the main task of psychoanalytic music therapy to understand these.

Let us begin to reflect upon scenes that occurred:

Obviously, the singing in the ritualised group session offered Mr. K. some form of relief. This meant that from the start of the session he was no longer compelled to cry out. The scenic context of the group gave him a first point of support. When the song “Do You Know How Many Tiny Stars There Are?” was sung, he was very moved. This song has both childhood connotations and a religious content. In Germany, it is normally sung at kindergarten, primary school and during services for children. We don’t know in what context Mr. K. learnt it. The words of the song are about how everyone is of value because no one is overlooked. The author has chosen a metaphor for this message: The picture of the sky with the stars God has counted. If we compare the message of the song with the ritual at the beginning of each singing session, it becomes clear that singing this song was a way of “naming” the transference, which was enacted:

I greeted each member of the group personally by name, thus expressing my esteem for each individual.

For Mr. K., however, the emotional experience in “naming” this scene was so closely connected with unfulfilled yearnings that he felt great sadness. He wept in a heart-rending fashion.

By crying, he caused me and the trainee, and later the nurse, to “play along” in the way he desired by sitting down next to him and comforting him. This seemed to be a pleasant repetition pattern for him; at home, his daughter and sister-in-law were both there to help him. So Mr. K. was able to make women take on a motherly role and give him comfort and help.

In the second scene, when Mr. K. was yelling at midday, my sympathy also led me to adopt a motherly role towards him. This scene was in many ways similar to that at the end of the singing session. Again, I sat down next to him. The song about the Morning Star
occurred to me. Through my singing I tried to take up the mood that had arisen and use it to bring across a message. “How beautiful Shines the Morning Star” is a well-known hymn from the Protestant hymn book in Germany. Like the song about the stars, it comes from a religious context. The songs also both have connotations about integration into the universe. In addition, the words of the Morning Star song combine Christian, religious elements with a love song. The Morning Star, Venus, is idealised and at the same time acts as a metaphor for the fulfilment of an ancient prophecy concerning the coming of the Redeemer. So the words of the song – especially when seen against the background of the song about the tiny stars – emphasise once again the uniqueness of each individual. In contrast to the other song, however, the hymn about the Morning Star also expresses the desire to become one with the universe and to be redeemed. Obviously, this song expressed and fulfilled exactly what Mr. K. was lacking.

In other words, there had been a process of transference from the beginning, and I had let myself become involved. In the group session, I had taken on the role of an object providing missing recognition and esteem, and in the second episode I took on that of an idealised, subjective object. Because my actions and choice of song defined this, Mr. K. was able to stop crying out and fall asleep with the feeling of being supported.

*But how can we understand this stereotyped crying-out against this background?*

As I have already mentioned, the scenes with the songs opened up the area of sensual-symbolic forms of interaction, of transitional objects and –phenomena. We know that the very first transitional actions occur in an infant when it is only a few month old. A satisfied infant, for example, begins play around with its voice by babbling, even when the mother is absent. With this auto-erotic game, it gradually makes steps that lead to a differentiation between the self and the object. This succeeds if the mother adapts sufficiently to the needs of the child. Vocal noises are particularly suitable for these transitional actions. This is because while producing them, the child experiences them as belonging to itself as well as hearing them as coming from outside. In this way, they gradually take up the position of a third party, mediating between an arising feeling of outside and inside. This gives the child the illusion of the mother’s being present, even though it is slowly breaking away from her. This activity can thus serve to allay deep, depressive fears.
Winnicott (1971) also describes how this process can fail. He relates how a 7-year-old boy was brought to him with several peculiar compulsive symptoms. Above all, the child was obsessed with anything that involved string, and used to tie objects together in a compulsive manner. It turned out that he had been separated from his mother several times when he was very young. What’s more, the mother had sometimes been emotionally unavailable to the boy because of a depressive illness. Winnicott interprets this compulsive behaviour as an act of denial, with which the child tried to undo the separation from its mother.

The compulsive character of this transitional action thus represents a failed interaction: one with a subjective object that is not sufficiently available.

If we compare the child’s symptom with Mr. K.’s cries, we have to say that the cries occurred on a far more regressive level than the compulsive activities with string. In the scale of transitional actions, noises tend to belong to the first stages of development, while activities involving objects belong to a more mature stage. Furthermore, we mustn’t forget that Mr. K. was an old, experienced man. However, the symptoms resemble each other in their structure. Both are patterns of activity isolated from the affection of unsuccessful experiences of interaction with a subjective object, and both serve to ward off an unbearable separation situation. And Mr. K. was also in such a situation: he was in the process of parting from the world. I see his cries therefore as desperate attempts to secure his self in a situation involving archaic fears of fragmentation, fears he was exposed to in the process of dying. By denying the unbearable interaction experience of being existentially abandoned, he also tried to banish the resulting emotional state from his perception. This emotional state turned at first into a grief during the group scene which “named” it by offering him support and esteem, and then found expression in a complementary counter-transference on my part and that of his carers – in the form of a sympathy that moved us to comfort him.

Through the singing of the Morning Star hymn against the background of this comfort scene, enough good representations of a supportive, subjective object could be activated for him to allow his ego functions to become unintegrated and fall apart. He calmed down and fell asleep. This also means, however, that a regressive development was introduced at that moment. This is the opposite process of development to that we know from children.
With children, transitional actions open up the outside world. But Mr. K. was able to permit himself to fall as part of the dying process.

It is surprising how quickly Mr. K. could be comforted once the “magic word” had been found. The scene with the Morning Star hymn obviously contained precisely the answer and expression he needed to be able to cease his attempts at securing his self. In his essay “The genetic sources of Freud’s difference with Romain Rolland on the matter of religious feelings” M. Wangh (1989) proposes the theory that the early experiences with the mother determine whether dying can be experienced as a peaceful merging with the universe, or as confusion, a feeling of being destroyed or abandoned. In the case I have been describing, this would mean that Mr. K. in principle had had enough supportive experiences with a good mother for these to be able to be activated. They had only been temporarily buried. The suddenness of the change also suggests, however, that he urgently needed them to be activated as part of the process of dying. Music gives us an excellent method to reactivate and give expressive form to such early experiences.

Text 1:

Do you know how many tiny stars there are
in the blue canopy of heaven?
Do you know how many clouds sail
far over all the earth?
The Lord God has counted them all
and not missed a single one
of their great number
of their great number.

Do you know how many gnats play
In the sun’s warm glow?
How many tiny fish cool themselves
In the clear waters?
The Lord God called them by name
So they all came to life
And are now all so merry.

Do you know how many children
rise from their beds early in the morning
and, carefree,
happily spend their day?
God in Heaven
has his pleasure in each of them,
and knows and loves you, too,
and knows and loves you, too.

Text 2:

How beautiful shines the Morning Star,
Full of mercy and truth before the Lord,
the sweet root of Jesse
You Son of David from Jacob’s line
My King and my Groom
You have taken possession of my heart
Lovely, friendly, beautiful and glorious,
magnanimous and honest, rich in gifts,
High and splendidly sublime.

5.0 Literature

S. Freud: Jenseits des Lustprinzips in: Das Ich und das Es, Fischer, FfaM 1994

A. Lorenzer: Sprachzerstörung und Rekonstruktion, Suhrkamp, FfaM, 1973

Sprache, Lebenspraxis und szenisches Verstehen, Psyche 37, 1983

D. Niedecken: Einsätze, VSA- Verlag, Hamburg 1988


Barbara Dehm-Gauwerky: Heinrich-Sengelmann-Krankenhaus, Kayhuder Str.65, D-23863 Bargfeld-Stegen, priv. Eschenweg 50, D-22949 Ammersbek, e-mail: dehm-gauwerky@web.de

Here is the October issue of Music Therapy Today.

We are proud to present to you “The Dynamics of Arts Integration” written by a New York based artist, teacher and supervision specialist, Prof. Enrico Giordano. He uses art in its different shades and colours to express - and to help others to express - what they cannot say. Petra Kern, our international editor, met him on an airplane describes how she met him:

“On my way back from the PhD course at Aalborg University, Denmark, I met Enrico Giordano on flight SAS 909 to Newark, New York. When taking off, Enrico started to make sketches from the pictures that the aircraft’s video camera was broadcasting. My curiosity was great enough to ask him what he was doing”.

A friendly conversation got them talking and resulted in this exciting contribution. Enrico Giordano is the Chairman of the Fine Arts Department at the College of Mt. St. Vinces, New York City. He is a visual artist as well as an Integrated Arts Specialist. In his studio, The Hudson River Arts and Design Center at the College of Mt. St. Vinces, he conducts workshops for teachers and children from the New York City public school districts to enhance classroom curricula by fostering creativity in teachers and students. When Enrico talked about his ideas and visions, the bridge to music and music therapy in educational settings was easy to build. His attitude and the way he sees his work has much in common with our profession. As an Integrative Arts Specialist, he uses the unique yet universal potential of arts to find new ways of educating children and to release deeply suppressed feelings. He guides the teachers and children to access their creative sources for learning and coping with difficult events.

In his article you will read why he includes drawing, painting, performing, poetry, music, rituals, environmental art, history and mythology in his workshop, and how he creates a holistic and open platform for academic, personal and community growth.
As Petra says, “Sharing our thoughts, dreams and visions on the flight was very inspiring. We came up with crazy ideas, hopes and dreams. What they will come to is still up in the air!”

Coming back down to earth, our next featured article “Therapeutic methods of experienced music therapists as a function of the kind of clients and the goals of therapy“ comes from Klaus Drieschner and Almut Pioch in the Netherlands. This article addresses how a client-centred therapy determines the goals of that therapy and the form that the therapy takes. This work was presented for the first time at the 2001 EMTC conference in Naples. We would like to share with you the emergence of this important empirical study into the real world of doing music therapy.

Another real world question of doing music therapy, reflecting what happens and searching for answers, leads Lony Schiltz to the following statement: “It is easier to prove the effectiveness of music therapy than to understand why it works”. Her paper entitled “Is the action of music therapy specifically linked to the underlying personality organization?” takes psychoanalytic oriented music therapy perspective, and investigates the psychopathology of psychotic, borderline and neurotic personality using qualitative and quantitative methods.

Another question concerning practice comes from Jeff Hooper. He asks – with a certain smile, as you will see in his photo- “Is Vibroacoustic (VA) therapy, music therapy?” In Europe, music therapy is traditionally seen as a process that develops from an ‘active’ musical relationship. In contrast, VA therapy is a ‘passive’ intervention that transmits pre-recorded music to the body through speakers built into a chair, table or bed unit. In the light of this, the author concludes by asking – is VA therapy music therapy?

The main theme of the articles in this Music Therapy Today issue is re-searching the real world of your daily therapeutic work. And let me consider another thing. As we are engaged in health care, we should care for our own health as much as we talk and write about health. Not only for ourselves but to be a role model for our patients. Recently, thinking about this I was facing my doctor, complaining about low back pain (always sitting, sitting, sitting…). He said to me he knows exactly about this pain. He gave me a prescription, and on my way out, I saw a sheet of paper fall down from the desk. There we stood, both with our low back pain, staring at the sheet of...
paper on the ground, and started laughing. He should have stayed at home to cure his own back pain, but some kind of professional attitude pulled him to work and slowly downwards to this piece of paper on the ground.

Maybe we have to take care of our own health care needs too! Take a look at the people in the picture below taken in Oxford this year at the World Congress. They look as though they are taking care of themselves. Perhaps this is a theme for discussion “How do we as carers take care of ourselves”? If you have any comments then please submit them to me joergf@uni-wh.de. We also have a discussion board you might like to explore. Or even submit a new topic yourself!

![Image of people at the World Congress](image.jpg)

**Competition:**

The next European conference 2004 in Jyvaskyla, Finland knocks lightly on your door. One of the smiling faces in picture above will be organising the next EMTC event together with some other colleagues. Name that person and the first five who mail the right answer to joergf@uni-wh.de will receive a small present.

Until we read again,
Joerg Fachner
Is the action of music therapy specifically linked to the underlying personality organization?

Lony Schiltz

Abstract

Does music therapy have an influence in general or is it linked to personality of the client? From a stance of psychoanalytic oriented music therapy an investigation into the psychopathology of psychotic, borderline and neurotic personality was conducted and researched with qualitative and quantitative methods. Referring to research on a clinical background single case illustrations were used to outline music therapy processes in question. It seems that the specific action of music is quite specific at the three main levels of personality organization. While the most dramatic changes may be obtained with borderline adolescents the exact mechanism of the action of music therapy remains a mystery and needs further investigation. It is easier to prove the effectiveness of music therapy than to understand why it works.

Introduction

Whereas there is a general scientific concern for investigations into the exact mechanism of the effectiveness of music therapy, most publications
Clinical background

Is the action of music therapy specifically linked to the underlying personality organization?


Clinical background

Clinical experience suggests, however, that music therapy acts rather specifically in the three main clinical groups, distinguished by psychoanalytical psychopathology, i.e. the psychotic, borderline and neurotic personality organization. Within these categories, however, action seems to be similar.

According to the psychoanalytical psychopathology, it is possible to distinguish three types of underlying personality organizations, independent of the overt symptomatology.

The neurotic structure has been studied since the early stages of psychoanalysis, but there are recent developments in the understanding of the process of subjectivation in adolescence. Concerning the psychotic structure, there are new insights helping to understand how it can function in a pseudo-normal manner. As for the borderline personality organization, a broader definition has been recently discussed, based on the preeminence of archaic defense mechanisms, such as splitting, denial, projective identification, idealization, resulting in a large number of conduct or personality disorders, ranging from overadaptation and false self to auto or heteroaggressive acting out and antisocial behaviour.

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Some illustrations of the musictherapeutic process

In a developmental perspective, Paulina Kernberg\textsuperscript{1} and her colleagues show the difference between the underlying borderline personality organization and the classical surface traits of the borderline personality disorder, with material drawn from their own clinical research and practice. They assume that some behavioural patterns meeting the criteria of the DSM for adult psychopathology may be assessed already in childhood and in adolescence. Differential criteria for conduct disorders on the neurotic, borderline and psychotic level are now discussed in the clinical literature, especially in the USA and in France.\textsuperscript{2}

\textbf{Some illustrations of the musictherapeutic process}

Music therapy seems to act in a specific way, in relation with the underlying personality organization. With a psychotic client music helps to establish an archaic form of communication, but its specific aesthetic qualities interfere very little with the therapeutic process. As an example, I shall quote Dany, suffering from a childhood psychosis leading to a secondary autistic retreat\textsuperscript{3}, expressing his archaic annihibation anxiety through a delirium focussed on a world-wide war, natural catastrophes, epidemics, hunger and the death of millions of people. Beating the con-gas gave him a short moment of relief, then he continued to fantasize. The terrific fantasies of destruction ceased to haunt him, when he recognized his own hatred against a person of his family, who had made him

\textsuperscript{1} KERNBERG P., Personality Disorders in Children and Adolescents, Basic Books, New York, 2000
\textsuperscript{3} SCHILTZ L., Un adolescent au psychisme embrasé par la haine La Revue de Musico-thérapie, 1999, XIX, 4, p. 131-133.
suffer for years by physical and mental violence and against classmates who had tortured him. After a psychoanalytically oriented music therapy of three years, he has made great progress in his psychological insight, in discriminating between reality and imagination, in his comprehension of other people and in the integration of social rules. He has made a professional choice according to his gifts and he is now successful in higher education. He never achieved to play in a musical manner, but music was nevertheless an important part of his psychotherapy. It was like an island where he could retire from his overwhelming destructivity.

On the other hand, the artistic pleasure is very important for the neurotic structure. Toni, a young man suffering from obsessional compulsive disorder from the beginning reached a high standard in his musical improvisations, in melodic invention, rythmical and dynamic variability and in formal structuring, without any prior musical training. His music was free from any compulsional or obsesional marks and he seemed to draw an immediate artistic pleasure from it, as if the neurosis had not touched the creative part of himself which was at once available for his self-fulfilment. His obsessions had much diminished after six months of treatment.

In the borderline personality organization, music therapy shows its maximal effectiveness, as a real tool of metabolization of archaic fears and desires into the conscious self. In borderline adolescents, I have also encountered the greatest progress in the personal musical playing style and in the integration of the so far separated musical parameters; at the same time, there could be noticed a positive evolution in the pulsional and emotional control and in the power of imagination and symbolic elaboration. At the beginning, rythm and melody were often used to sat-


Some illustrations of the musictherapeutic process

...isfy different emotional needs. Pure rhythm, leading to an emotional and physical discharge was chosen by those who had unfulfilled narcissistic needs, while pure melody was chosen by those who suffered from depression behind a surface of overadaptation.¹ The search for a stable basic pulsion, a rhythmical, ostinato or merely a temporal link could be noticed with those who had to develop an internal control over their chaotic feelings and drives².

*Christina* suffered from hypochondriac concern, separation anxiety and terrific nightmares. Traumatized by the presence of a paralytic and depressive father, she clung to her mother in a fusional manner. Her quest for a restoration of the paternal function was accompanied by an exclusive fixation on the long lasting vibration of the gong and the chime bars. At the beginning, she could neither invent melodies nor produce a lively rhythm. Neither could she participate in a musical dialogue, being unable to feel any basic pulsion. Her music was quite chaotic, without the least temporal structure. She gradually moved from regression, over a period of cathartic, emotional and pulsional discharge to differentiation and formal musical shaping. After one year of weekly music therapeutic sessions, accompanied by symbolic elaboration, she was able to express her guilt and aggressivity directly, where as she began to oppose resistance to her mother in every-day-live. Her playing style had become energetic, flexible and creative at last.³

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¹ SCHILTZ L., Restaurer la capacité de rêver, La Revue de Musicothérapie, 2000, XX, 1, p.7-21.
² SCHILTZ L., Morosité, déficience rythmique et blocage imaginaire. 2001, Revue française de Psychiatrie et de Psychologie Médicale.
A scientific study of the music therapeutic process

I shall now present some results of a study comparing the evolution of neurotic and borderline adolescents treated by analytically oriented music therapy.\(^1\)

A qualitative and quantitative analysis of the modifications observed in projective tests during the music therapeutic process shows that the responses of borderline clients and of neurotic or normal ones are gradually coming closer.

A follow-up study, including external control criteria, has shown that these modifications are durable and correspond to a real evolution on the structural level.

HYPOTHESES

The main hypothesis of the research was that adolescents, presenting various forms of conduct disorders related to an underlying borderline personality organization, could be effectively treated through analytically oriented music therapy, because of its possibility to lead to an imaginative and symbolic elaboration of violent phantasms, allowing the canalisation and integration of destructive drives into the conscious self and reducing the tendency towards auto- and hetero-aggressive acting out or towards an emotional and pulsional blockade. At the end of the treatment, their answers to projective tests would come closer to those of the control group of neurotic or normal adolescents.


The main hypothesis was subdivided into 5 operational hypotheses, liable to be put to the test:

- H1: With neurotic or normal adolescents, there is an important elaboration of aggressivity in the realm of imagination and cognition. This cathartic function will appear in their literary production, whereas on personality questionnaires, their aggressivity scores will be moderate.
- H2: In the clinical group, a significant lack in the imaginary and symbolic elaboration of aggressive drives will be objectified through the analysis of the literary production and the projective tests; in the psychometric tests their scores on aggressivity and anxiety scales will be excessively low or high.
- H3: Under music therapy, there will be a compensatory evolution in the clinical group, leading towards a better integration of the impulses and emotions and an increased capacity to deal with these forces in a creative and artistic way, attested by the evolution of their literary and musical production.
- H4: In the clinical subgroups (inhibition and blockade versus desinhibition and acting-out) the action of music therapy will be differentiated, because different basic needs have to be satisfied, before their creativity can fully develop.
- H5: The effects of music therapy will lead to significant changes in the literary production, in the musical production, and in some prevailing verbal and non-verbal behavioural patterns; external validity criteria will show the transference of these modifications into normal life and their stability over time.

METHODOLOGY

Experimental design. The design of the research I undertook for this proposal is the best compromise I could obtain between the richness and complexity of clinical intuition and the aim to check my subjective conclusions with a strict methodology. While working with clinical groups in a natural environment, we are reduced to using a quasi-experimental design. But even in this case, according to Raulin et Graziano it is possible to obtain valid and viable conclusions, if we take some precautions,

A scientific study of the music therapeutic process

consisting in the evaluation and neutralization of the influences which could possibly interfere with the independent variable. The constitution of a control group and the introduction of external validity criteria respond to the same demand of scientific objectivity. Without a control group, you could always say that the positive modifications are due to spontaneous maturation or to the vicissitudes of personal history. Without external control criteria, you could not say whether there is a transference from the therapeutical situation to real life.

TABLE 1. A summary of the experimental design: Hypotheses and steps of verification

<table>
<thead>
<tr>
<th>H1: Working out of aggressivity on the imaginary and symbolic level with normal or neurotic adolescents.</th>
<th>Study of the imaginary aggressivity in the control group with projective and psychometric tests. Study of the differences linked to age and gender.</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2: The dysfunctioning of the imaginary or symbolic working out in the clinical group.</td>
<td>Study of the imaginary aggressivity in the two clinical subgroups, characterised by inhibition versus desinhibition, with psychometric and projective tests. Comparison of the clinical group to the control group and of the clinical subgroups to each other.</td>
</tr>
<tr>
<td>H3: Compensatory evolution in the clinical group receiving music therapy sessions.</td>
<td>Pretest-Posttest comparison of the clinical group with projective tests, psychometric tests and observational frames.</td>
</tr>
<tr>
<td>H4: Differential efficacy of music therapy in the two clinical subgroups.</td>
<td>Pretest-Posttest comparison of the clinical subgroups on all the variables.</td>
</tr>
<tr>
<td>H5: The lasting modifications produced by music therapy.</td>
<td>Pretest-Posttest comparison of the clinical group and the control group with projective tests, psychometric tests, observational frames, questionaries for auto-evaluation and in reference to external criteria, such as school results and creative leisure activities.</td>
</tr>
</tbody>
</table>
A scientific study of the music therapeutic process

I shall present some examples of the numerous quantitative and qualitative findings.

I. Synthesis of the phenomenological analysis of the group structure.

TABLE 2. Baroque Music

<table>
<thead>
<tr>
<th>Subgroup I</th>
<th>Subgroup D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td></td>
</tr>
<tr>
<td>A deceptive happiness</td>
<td>Discord</td>
</tr>
<tr>
<td>Stage 2</td>
<td></td>
</tr>
<tr>
<td>Access to a sound rivalry</td>
<td>Access to a sound rivalry</td>
</tr>
</tbody>
</table>

TABLE 3. Ethnical Music

<table>
<thead>
<tr>
<th>Subgroup I</th>
<th>Subgroup D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td></td>
</tr>
<tr>
<td>Helplessness of the victim of aggression</td>
<td>Merciless struggle until the final victory of one of the protagonists</td>
</tr>
<tr>
<td>Stage 2</td>
<td></td>
</tr>
<tr>
<td>Ages of life and civilizations</td>
<td>Ages of life and civilizations</td>
</tr>
</tbody>
</table>

TABLE 4. Romantic Music

<table>
<thead>
<tr>
<th>Subgroup I</th>
<th>Subgroup D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td></td>
</tr>
<tr>
<td>Display of one's unsatisfied affective needs</td>
<td>Struggle for the satisfaction of one's personal needs</td>
</tr>
<tr>
<td>Stage 2</td>
<td></td>
</tr>
<tr>
<td>Quest for love and adventures</td>
<td>Quest for love and adventures</td>
</tr>
</tbody>
</table>

In the stories written under musical induction, we assist in an exemplary manner to the reduction of the conflict to a more human and socialized
A scientific study of the music therapeutic process

dimension, to the acceptance of one's limitations, to a better balance of the narcissistic and objectal needs, to an evolution towards the concerns about love life, shared by most adolescents. Together with a spectacular reduction of the mechanism of splitting, this growth towards emotional maturity points to structural changes in the underlying personality organization, in the whole clinical group. There is a similar evolution in both clinical sub-groups.

II. Pretest- Posttest comparison of the clinical subgroups and the control group to each other:

- Reactions to musical extracts

<table>
<thead>
<tr>
<th>Variables</th>
<th>Difference of means</th>
<th>Student's t</th>
<th>Significance (one tailed)</th>
<th>Orientation of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>- 2,50</td>
<td>- 9,13</td>
<td>&lt; 1 %</td>
<td>Pré &lt; post</td>
</tr>
<tr>
<td>Cre</td>
<td>- 1,56</td>
<td>- 4,42</td>
<td>&lt; 1 %</td>
<td>Pré &lt; post</td>
</tr>
<tr>
<td>Sen</td>
<td>- 0,88</td>
<td>- 4,24</td>
<td>&lt; 1 %</td>
<td>Pré &lt; post</td>
</tr>
<tr>
<td>Pro</td>
<td>- 1,24</td>
<td>- 3,44</td>
<td>&lt; 1 %</td>
<td>Pré &lt; post</td>
</tr>
<tr>
<td>Vec</td>
<td>1,27</td>
<td>3,11</td>
<td>&lt; 1 %</td>
<td>Pré &gt; post</td>
</tr>
<tr>
<td>Imp</td>
<td>- 1,06</td>
<td>- 2,87</td>
<td>&lt; 1 %</td>
<td>Pré &lt; post</td>
</tr>
</tbody>
</table>

a. Age = elaborated aggressivity, Cre = creativity, Sen = sensitivity to the emotional expression, Pro = productivity, Vec = depressive feelings, Imp = emotional and bodily implication

In the clinical subgroup I, we see a significant increase of the elaborated aggressivity, of the sensitivity to the expression of emotions, of the quantitative productivity, of the emotional and bodily implication, and a significant reduction of the depressive feelings.
A scientific study of the music therapeutic process

In the clinical subgroup D, we see a significant increase of the elaborated aggressivity, of the qualitative creativity, of the quantitative productivity, of the bodily and emotional implication, of the sensitivity to the expression of emotions, and a significant reduction of anxiety.

The findings in the two clinical subgroups are very close; the fact that music therapy leads to a similar evolution, independent of the diversity of prior surface symptoms, speaks in favour of the broader conception of a common borderline personality organization underlying a great variety of conduct disorders.

### TABLE 6. Subgroup D: Student's t Test for matched groups

<table>
<thead>
<tr>
<th>Variables</th>
<th>Difference of means</th>
<th>Student's t</th>
<th>Significance (onetailed)</th>
<th>Orientation of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>- 2,29</td>
<td>- 4,99</td>
<td>&lt; 1 %</td>
<td>Pré &lt; post</td>
</tr>
<tr>
<td>Cre</td>
<td>- 1,35</td>
<td>- 4,39</td>
<td>&lt; 1 %</td>
<td>Pré &lt; post</td>
</tr>
<tr>
<td>Pro</td>
<td>- 1,24</td>
<td>- 4,24</td>
<td>&lt; 1 %</td>
<td>Pré &lt; post</td>
</tr>
<tr>
<td>Imp</td>
<td>- 0,94</td>
<td>- 3,24</td>
<td>&lt; 1 %</td>
<td>pré &lt; post</td>
</tr>
<tr>
<td>Ang&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1,40</td>
<td>3,50</td>
<td>&lt; 5 %</td>
<td>pré &gt; post</td>
</tr>
<tr>
<td>Sen</td>
<td>- 0,65</td>
<td>- 2,39</td>
<td>&lt; 5 %</td>
<td>pré &lt; post</td>
</tr>
</tbody>
</table>

<sup>a</sup> Ang = anxiety

### TABLE 7. Groupe C: Wilcoxon's Sign- Rank Test

<table>
<thead>
<tr>
<th>Variable</th>
<th>Z</th>
<th>Significance (twotailed)</th>
<th>Orientation of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sen&lt;sup&gt;a&lt;/sup&gt;</td>
<td>- 2.070</td>
<td>&lt; 5 %</td>
<td>Pré &lt; Post</td>
</tr>
</tbody>
</table>

<sup>a</sup> Sen = sensitivity to the emotional expression
In the control group, the only significant change concerns the sensitivity to the expression of emotions. The other variables have remained stable during the treatment period.

A comparison between groups (clinical to control group) at the beginning and at the end of the therapy shows that their responses to projective tests are actually becoming closer. In the clinical group, projective tests reveal now a better balance between primary and secondary defense mechanisms, a humanization of the parental representations and of the self-concept, a better equilibrium between the Ego Ideal and the Super Ego and a new capacity of intrinsic motivation.

**Discussion**

How can we explain this capacity of music therapy to lead to structural modifications i.e. to durable changes in the established economy of defense mechanisms? It is easier to prove the effectiveness of music therapy than to understand why it works.

Here is a diagram summarizing my own comprehension of the action of music therapy with borderline adolescents.
Discussion

Is the action of music therapy specifically linked to the underlying personality organization?


This diagram is but a general frame allowing to study a great number of specific questions, contributing eventually to the formulation of a general theory of the action of music therapy with borderline adolescents.

In the neurosis and in the psychosis, the action of music seems to be quite different. In the neurotic structure, music therapy allows to retreat from the requirements of a severe Super Ego into the realm of intrinsic motivation and creative autonomy, whereas in the psychosis, the basic secu-
rity needs seem to be gratified by the action of rhythm and vibrations, allowing the patient to feel alive again and to overcome the archaic annihilation anxiety, at least for a short moment.

**Conclusion**

It seems to me that the specific action of music is quite specific at the three main levels of personality organization. While the most dramatic changes may be obtained with borderline adolescents the exact mechanism of the action of music therapy remains a mystery and needs further investigation. Only some trails have been explored so far and many questions are left unanswered. This is a great challenge for future research.

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ADDRESS: Lony Schiltz (Ph.D.)
Centre Universitaire de Luxembourg, Université Paris-V,
Luxembourg, le 3.4.2001
10, rue Gabriel de Marie
Is the action of music therapy specifically linked to the underlying personality organization?

References:

L-2131 Luxembourg
Tel/Fax 00352 433668
Is VA therapy, music therapy?

by Jeff Hooper

Abstract

The paper examines the theoretical background to VA therapy and introduces four very different VA systems. It discusses research carried out with these systems.

In Europe, music therapy is traditionally seen as a process that develops from an ‘active’ musical relationship. In contrast VA therapy is a ‘passive’ intervention that transmits pre-recorded music to the body through speakers built into a chair, table or bed unit. In the light of this, the author concludes by asking – is VA therapy, music therapy?

Introduction

In 1959 Teirich – a doctor – undertook one of the earliest studies into the therapeutic effects of music and vibration. He was motivated by the case study of a deaf mute who, at the age of 59, discovered the ability to enjoy music. Sutermeister – the deaf mute – described how, with his back as the main “receiving station”, he received sound waves through “an inner

The Theoretical Background To VA Therapy

Teirich built a couch which contained loud speakers and which transferred vibration from J.S. Bach’s D minor Toccata and Fugue straight to the solar plexus. He used his fellow doctors as a subject group. They variously reported immediate warmth in the solar plexus, a feeling of complete relaxation in the stomach and a very pleasant dream-like state.

Teirich’s work pre-dates the development of vibroacoustic (VA) therapy by around 20 years. It can seen as an inspiration to those who developed VA therapy.

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The Theoretical Background To VA Therapy

A sound wave is produced when an elastic medium – solid, liquid or gas – is compressed and then expanded in a regular way. Any vibrating object is a source of sound – the taut string of a piano; the vibrating plate of a drum or the column of air in a flute. In addition, air which rushes past an obstacle fast enough to cause turbulence (e.g. a whistle) also generates sound waves. The pitch of a sound is determined by the frequency at which the vibrations occur. The units of frequency are called Hertz (Hz). 1 Hz is equal to one vibration per second. A vibration 100Hz and above is referred to as high frequency, a vibration below 100Hz as low frequency.

The human ear is sensitive to frequencies between 20Hz and 20,000 Hz. Frequencies above and below the range of human hearing are called ultrasonic and infrasonic respectively, and are usually referred to as “not audible sound”. In medicine ultrasonic sound waves are being used like X-rays or in place of certain surgical procedures (e.g. shattering kidney stones).
The Theoretical Background To VA Therapy

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Music Therapy Today (online), available at http://musictherapyworld.net

stones into harmless fragments). While hand-held infrasonic acoustical vibratory devices, which deliver chaotic sound in a low frequency range of 8-14Hz, are being used by chiropractors to relieve joint and muscle pain.

In contrast to the application of ultra and infrasonic sound waves, VA therapy chooses frequencies which fall within the range of human hearing. In doing so, VA therapy draws on an almost universally accepted principle of sound and music, namely, that exposure to soft, low frequency and non-rhythmic music – ‘sedative’ music for short – results in physiological responses indicative of relaxation. This principle may not always be supported by the research literature. Nevertheless, trends have been identified which confirm that ‘sedative’ music encourages relaxation (Maranto, 1993a; Bartlett, 1996; Dileo, 1997).

VA therapy also recognises the physical effects of sound. In particular the evidence that subjects are sensitive to differing levels of mechanical vibration when these are applied to the body. For example, changes in skin temperature have been identified that are dependent on the amplitude of vibration (Skoglund and Knutsson, 1985; Skoglund, 1989).

It is these pieces of evidence – the relaxing effect of ‘sedative’ music and the vibratory sensitivity of subjects – which form the theoretical basis for the use of music as an auditory, as well as a vibratory, stimulus in VA therapy. In the tradition of Teirich, VA therapy transmits music to the body through loud speakers built into a chair or bed unit. In this way the music is often said to be both perceived by the ears and felt with the entire body.
VA Equipment

The development of VA equipment has not been confined to one product or one country. The paper briefly traces the development and describes the specifications of four pieces of VA equipment.

The only book published to date on this intervention - *Music Vibration and Health* (1997) - proved a valuable source of information. It documented a variety of clinical and research studies, discussed treatment procedures, ethical practice and contraindications and provided information that contributed to all the sections of this paper.

In 1982 Olav Skille, a Norwegian educator and therapist summarised the process of vibroacoustics as “the use of sinusoidal, low frequency sound pressure waves between 30-120 Hz blended with music for use with therapeutic purposes.”

Skille had begun developing the principles and methods of VA therapy when, his interest in the physical effect of sound, prompted him to investigate whether sound vibration would relax severely physically and mentally handicapped children and help reduce muscle tone. He encouraged relaxation by playing music through loud speakers pressed against beanbags the children were lying on. His work culminated with the manufacture and marketing of the VibroAcoustic chair (VA100) and bed (VB500) by a wholly owned Norwegian company (VibroAcoustics AS). The first units were produced in 1988-1989.

The VA100 (and VB500) used stereo tapes that combined relaxing music and a single low frequency rhythmically pulsed sinusoidal sound wave. Music, composed to encourage relaxation, was on one channel of the tape.
and the same music with a single pulsed low frequency sound added on the other. The pulsed effect was created by the difference in tone between two sinusoidal tones placed close together (e.g. 40Hz and 40.5 Hz). Skille introduced the element of low frequency sound as he believed that the bass frequencies in music played a significant part in encouraging relaxation.

The stimulus was carried to different areas of the body by six 20-1500Hz loudspeakers positioned within the chair. It was sent to the speakers in the chair via a control unit (SU200). The control unit performed three functions. It allowed the intensity of the stimulus to be adapted for each area of the body. It controlled the balance between the music and pulsed tones so that a patient, if they wished, could listen to music alone. It controlled the volume at which a patient could experience the music component of the treatment through headphones.

VibroAcoustics played a defining role in the development of VA therapy. It went out of production in 1994.

**PHYSIOACOUSTIC THERAPY**

The components of the Physioacoustic system, used in Physioacoustic therapy, are a mattress, a computer unit, an audio system and a power source. There are four transducers set into the mattress and these are placed under the neck, lower back, thigh and lower leg areas. The Physioacoustic system combines low frequency sinusoidal sound and specially selected or composed music which is played through the audio system.

The sinusoidal sound is generated by the computer which also controls its frequency, pulsation and direction. The computer is programmed to make the sound vary between 27Hz and 113 Hz until, at a certain point,
the optimal resonance for a muscle group is produced and the muscle responds to the stimulation. The sound is pulsed in this way to secure a rest period and avoid the numbness often caused by continuous stimulation. The sound can be moved from the lower parts of the body upwards or in a reverse direction. The sounds and programmes can be modified for general relaxation, sleep induction or pulmonary physiotherapy.

Physioacoustic therapy was developed almost in parallel with VibroAcoustics. The first experiments were carried out in the 1970’s and were conducted, in Finland, by Petri Lehikoinen. The essential difference between the two systems is that while VibroAcoustics blends a single frequency sinusoidal sound with music, the Physioacoustic system generates and combines a range of sinusoidal frequencies with the music stimulus.

The Physioacoustic system is available commercially from Heritage Medical Products, Kalamazoo, Michigan, USA. In Finland, where the Physioacoustic chair is widely used by music therapists, it is manufactured and marketed by Next Wave.

(3) SOMATRON

In 1985, after being a professional artist for 23 years, Byron Eakin experimented with relaxation techniques by bolting a pair of speakers to a massage table in his garage. Today he heads the Somatron Corporation that produces a range of Somatron products. The majority of Somatrons are in the United States where they are used by music therapists and other health care professionals.

The current range of Somatrons includes the Clinical Recliner. The recliner has four speakers – two at ear-level and two 40-8000Hz vibro-
Acoustic speakers in the lower leg and back sections. The vibroacoustic speakers are fitted into an 11”x14” frame – a ‘vibroacoustic diaphragm’ – and this enhances the transfer of vibrations from specially composed vibroacoustic music.

Despite claiming to be the “world’s most widely used VA device”, the Clinical Recliner does not offer a blend of music and sinusoidal low frequency sound.

The Music Vibration Table (MVT) is constructed from a typical hospital procedural stretcher (Chesky and Michel, 1997). Its components are a base table, sound system, a computerised vibration feedback processing system and a vibrating membrane – the table top (Chesky and Michel, 1991). There is padding between the membrane and the subject to increase comfort during treatment (Chesky, Michel and Kondraske, 1996).

The vibrating membrane has three separate modules positioned under the torso, lower leg and thigh. Each module can be independently controlled. In each module the music selections are passed through a separate computerised vibration processing system. The processing system controls the magnitude and amplitude of the vibrations in the 60-300 Hz range and records the parameter and timing of stimulus variations (Chesky, Russell, Lopez and Kondraske, 1997).

Speakers can be connected to the system and these provide the subject with external sound. The loudness, which is controlled independently of the vibration levels, can be altered to each subject’s preferred level (Wigram, 1997a).
Kris Chesky developed the MVT after highlighting research which failed to control and measure the vibrations used and which, in his view, produced outcomes that were difficult to interpret (Michel and Chesky, 1996). He argued that it was not enough to report how each subject responded to a specific frequency or type of vibration. It was necessary for VA therapy to provide a measure of the vibration actually experienced by a subject. This he argued was achieved only by MVT. MVT was a system which monitored the sound or music generating the vibration. It also monitored the physical characteristics of the vibrating object (Chesky, Michel and Kondraske, 1996). MVT could be adjusted to compensate for individual differences in weight and displacement which interacted with the sound generating the vibration and the vibrating membrane itself (Chesky and Michel, 1991).

MVT is now a patented system, and development work is on going at the Texas Centre for Music and Medicine.

<table>
<thead>
<tr>
<th>Developer</th>
<th>VibroAcoustics</th>
<th>Physioacoustic therapy</th>
<th>Somatron</th>
<th>Music Vibration Table (MVT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developer</td>
<td>Olav Skille (Norway)</td>
<td>Petri Lehikoinen (Finland)</td>
<td>Byron Eakin (America)</td>
<td>Kris Chesky (America)</td>
</tr>
<tr>
<td>Product</td>
<td>VibroAcoustic Chair (VA100)</td>
<td>Physioacoustic mattress</td>
<td>Clinical Recliner</td>
<td>MVT</td>
</tr>
</tbody>
</table>
TABLE 1. Summary of VA equipment

<table>
<thead>
<tr>
<th>Component</th>
<th>Stimulus</th>
<th>Current status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>-chair</td>
<td>-relaxing music</td>
<td>No longer available</td>
<td>Blends music &amp; sinusoidal sound.</td>
</tr>
<tr>
<td>-6 speakers</td>
<td>-music and single low frequency rhythmically pulsed sinusoidal sound wave.</td>
<td>Supplier: Heritage Medical Products, Kalamazoo, MI, USA.</td>
<td>Combines music and sinusoidal sound.</td>
</tr>
<tr>
<td>(20-1500 Hz)</td>
<td></td>
<td></td>
<td>A mattress through which music is played &amp; experienced as vibrations in the body.</td>
</tr>
<tr>
<td>-control unit</td>
<td></td>
<td>Supplier: Somatron Corporation, Tampa, FL, USA.</td>
<td>Provides a measure of the vibration experienced by a subject.</td>
</tr>
<tr>
<td>-audio system</td>
<td></td>
<td>Patented system.</td>
<td></td>
</tr>
<tr>
<td>-mattress</td>
<td>-specially selected or composed music.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-4 transducers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(27-113 Hz)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-computer unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-audio system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-chair</td>
<td>-vibroacoustic music.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-4 speakers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(40-8000 Hz)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-vibroacoustic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diaphragm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-audio system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-base table</td>
<td>-music chosen by the researcher.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-vibrating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>membrane (60-300 Hz)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-vibration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>processing system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-audio system</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MUSCLE TONE AND RANGE OF MOVEMENT.

When Olav Skille developed VibroAcoustics he believed it had the potential to relax people and reduce muscle tone – the natural tension in the fibres of a muscle. Wigram, who began by describing this response (Wigram and Weekes, 1989), later investigated the use of VibroAcoustics with cerebral palsy patients. He provided evidence that, when compared to using music alone, it produced a greater reduction in muscle tone and a greater improvement in the range of movement (Wigram, 1997b). For certain subjects VA therapy reduced the danger of fixed deformity and it was welcomed as a long-term preventative, as well as a treatment, intervention (Wigram, 1992). Individual case studies (Skille, 1997; Wigram, Mc Naught et al., 1997) and work with Rett Syndrome (Wigram, 1997c) offered further evidence of this response.

The Physioacoustic system has also improved range of movement. The subjects were elderly patients who had undergone total knee replacement (Burke and Thomas, 1997).

PAIN RELIEF.

There is anecdotal evidence that VibroAcoustics provides relief from the pain caused by conditions including polyarthritis, rheumatism and colic (Wigram, 1992; Skille, Wigram and Weekes, 1989).

When Skille provided an explanation for this he suggested that the effect of VibroAcoustics was like a gentle massage on every cell in the human body (Wigram, 1992). Byron Eakin echoed these thoughts when he described the Somatron as offering an “acoustical massage relaxing the entire body to the sound and feel of music.” In contrast the developers of MVT and Physioacoustic therapy provided a neurobiological explanation (Chesky and Michel, 1991; Chesky, Michel and Kondraske, 1996; Chesky and Michel, 1997). They suggested that VA therapy stimulated corpuscles that suppressed the pain impulse transmitted from nerve end-
ings to the brain, and triggered additional non-pain signals that had to be processed by the brain.

The MVT was developed specifically for use in pain relief. Chesky, Michel and Kondraske (1996) outlined a theory for using music vibration in pain relief. MVT, they argued, offered a two-pronged approach which combined the attention-distraction and affect dimensions of music (Brown, Chen and Dworkin, 1991) with the physiological effects of vibration. MVT was an intervention that could be made in advance of pain as well as in reaction to it. Consequently they believed that MVT had the potential to reduce the need for pre-operative sedatives, decrease post-operative pain and reduce the length of stay in hospital (Chesky and Michel, 1997).

Research into the effects of VA therapy on pain relief is still on going. Chesky has compared MVT with a control condition. To date he has established that MVT encouraged greater reductions in the pain perception of rheumatoid arthritis sufferers (Chesky, 1992) and, in a separate study, acted as a “possible supplemental intervention” for those with the diffuse musculo-skeletal pain of fibromyalgia (Chesky, Russell, Lopez and Kondraske, 1997). Individual case studies have also confirmed that MVT was a valuable post-operative intervention (Chesky and Michel, 1997) and reduced pain perception following treatment for an ankle strain (Chesky and Michel, 1991). Finally, studies carried out with the Physioacoustic system, highlighted its value in decreasing the pain perception of post-operative gynecological patients (Burke, 1997) and knee replacement patients (Burke and Thomas, 1997).
VA therapy has benefited patients with cystic fibrosis and reduced the severity of asthma attacks. It generated a vibration into the lungs and shifted mucus on the bed of the lung which caused a cough reflex to occur (Wigram, 1995).

The results of a study, carried out with cardiac patients, confirmed that Physioacoustic therapy could be used to improve cardiac input instead of adding or increasing heart support medicine (Butler and Butler, 1997).

VA therapy has been used with hearing-impaired subjects. Skille (1992) described a very positive response to the inclusion of Vibroacoustics as part of a rehabilitation programme. Darrow and Goll (1989) and Darrow (1992) provided evidence that the Somatron improved rhythm identification and pitch discrimination respectively.

Finally Lehikoinen (1997), described how a patient with a genetic brain disease responded positively to Physioacoustic therapy. There is evidence that the 40Hz brain wave disappears or is disturbed in the early stages of Alzheimer disease and some brain injuries (Llinas and Ribari, 1993). Lehikoinen suggested that Physioacoustic therapy, based as it was on the 40Hz frequency, reinforced this thalmus frequency and was a potential intervention for brain injured and stroke patients.

There is anecdotal (Clair and Bernstein, 1993; Lehikoinen, 1997; Chesky and Michel, 1997) and objective evidence (Madsen, Standley and Gregory, 1991; Walters, 1993) that VA therapy is pleasurable and relaxing. Consequently it has been used to address anxiety or anxiety related problems.
Research, which compared VibroAcoustics and a music intervention, indicated that VA therapy had a greater effect on the anxiety of ten subjects with an intellectual disability (Wigram, 1993), and, in a separate study with subjects who displayed self injurious behaviour, resulted in a greater tolerance of staff interactions (Wigram, 1993). It was suggested that VA therapy offered a pleasurable tactile experience which neutralised the element of self-stimulation within unprovoked self-injurious behaviour (Wigram, 1995). This diverting quality also reduced the anxiety of acutely ill children during invasive procedures (Jones, 1997) and encouraged autistic patients to be more open to interaction (Wigram, 1992).

Finally three studies suggested that VA therapy may offer an antidote for stress related conditions (Lehikoinen, 1988; Raudsik, 1997; Patrick, 1999). However, the results should be treated with caution. The researchers did not include blinding and may be reporting the effect of positive expectations.

Those involved in research with VA therapy examined the physiological responses of their subjects alongside the behavioural or psychological changes already discussed.

Anecdotal reports suggested that VA therapy encouraged a process of vasodilatation and improved blood circulation (Skille, Wigram and Weekes, 1989; Wigram, 1992). Otherwise, the results offered evidence of an inconsistent physiological response (Wigram and Weekes, 1989; Skille, 1992) or an absence of response (Madsen, Standley and Gregory, 1991). In addition, three separate studies suggested that physiological and behavioural responses to VA therapy did not always directly corre-
late. Subjects reacted with a rise in measured parameters yet had the same feelings of stress reduction and relaxation as clients with falling values (Skille, 1992) or vice-versa (Wigram, 1993; Serra, 1986). Finally, studies with non-clinical subjects compared VA therapy with other non-VA auditory conditions. Standley (1991a) revealed that physiological changes were not differentiated by treatment group. In contrast, (Wigram, 1997d) demonstrated a positive physiological response.

Despite the evidence that VA therapy promotes relaxation, it should not be assumed that this effect would always occur with all populations. For instance, Hooper and Lindsay (1997), who used the Somatron to treat anxiety reported a marked disparity in the response of two subjects with a learning disability. It is also unwise to anticipate that VA therapy will be more effective than a non-vibroacoustic intervention. A number of comparative studies have attributed no additional benefit to VA therapy (Wigram, 1997e; Kvam, 1997; Pujol, 1994; Burke, Walsh, Oehler and Gingras, 1995; Walters, 1996; Brodsky and Sloboda, 1997).

The research evidence has confirmed that VA therapy was an effective treatment for a variety of conditions. Consequently, attention has been paid to the training, skills and qualifications required to use VA therapy as a treatment modality and to contraindications.

Wigram (1996) provided possible contraindications for VA therapy based on theoretical assumptions, experience and guess work. Contraindicated conditions included psychosis, acute inflammation, pregnancy, haemorrhaging, thrombosis, hypertension and the use of pacemakers. These conditions are outlined in the specification details supplied with the Physioacoustic system and users who experience these difficulties are
Is VA Therapy, Music Therapy?

advised to gain approval from their physician prior to receiving VA therapy.

The current situation is that anyone can purchase and use VA equipment. Wigram and Dileo, (1997) voicing their concern about this position, outlined minimum requirements for its use in private practice or institutional settings. They suggested that practitioners should have a professional certification and/or training in a health care area and, in addition, specialised training in the use of music for VA therapy. Wigram and Dileo (1997) further suggested that music therapists may be qualified to practice this type of treatment.

Is VA Therapy, Music Therapy?

VA therapy is a very distinct form of treatment. Music therapists in the United States of America often feel more comfortable with it than their European counterparts. They frequently present music as a relaxant or as a contingent reinforcer, and the resulting therapeutic process does not always involve a dynamic and evolving musical relationship. In Europe there is a history of active music making in music therapy. Consequently questions are raised about the role of the music therapist in VA therapy, and the place of VA therapy in music therapy practice. In short – is VA therapy, music therapy?

Kenneth Bruscia (1989) defined music therapy as “a systematic process of intervention wherein the therapist helps the client to achieve health, using musical experiences and the relationships that develop through them as dynamic forces of change”. In doing so he identified three
essential elements – a systematic intervention, a therapeutic relationship and a musical experience. Does VA therapy meet each of these criteria?

A brief discussion of the role of music and music therapy in medicine is particularly relevant in an examination of the first criteria – providing a systematic intervention.

Music is now widely used in the medical treatment of a patient. Background music is regularly played in waiting rooms or in the operating theatre. In both these cases, while the music may have a therapeutic effect, it cannot be described as music therapy. Maranto (1993b) has outlined instances where the use of music in medicine may be regarded as music therapy. In each case music meets specific, and often individualised, therapeutic goals and it does so either by supporting a medical treatment, by acting as an equal partner or by being a primary intervention for a medical condition. For instance, by using background music to mask the aversive sound level of a neo-natal isolette, music therapists have helped facilitate homestasis and increased the neurological development of pre-term infants (Standley 1991b).

In keeping with this example, the research discussed illustrates how VA therapy has been used to support the medical treatment of pre-term infants (Burke, Walsh, Oehler and Gingras, 1995), as well as gynecological (Burke, 1997), cardiac (Butler and Butler, 1997) and post-operative patients (Burke and Thomas, 1997). VA therapy has also been provided as a treatment in its own right for high muscle tone (Wigram, 1997b), pain relief (Chesky, 1992) and anxiety (Jones, 1997). In each case VA therapy was employed in a systematic and goal orientated manner and fulfilled the first criteria in Bruschia’s definition.
By the very nature of the equipment – a bed, mattress or chair unit – VA therapy is an individualised treatment. Each VA therapy session involves introducing the patient to the equipment, ensuring they are comfortable, choosing the stimulus levels, monitoring their response in an unobtrusive way and at the end of the session offering reassurance, guidance and support. Clearly it is a treatment in which the therapist do build a relationship. It also calls on the skills of a music therapist not just for the selection of music but especially with non-verbal clients, in understanding and interpreting individual responses to the stimuli.

The author has introduced subjects with a learning disability to the Somatron. He has used the Somatron not as a treatment in its own right, but at the end of an active music therapy session. Persoons and de Backer (1997) have described the use of VA therapy prior to active music therapy. They noted an improvement in the interactions they experienced with two autistic and multiply handicapped clients during the active music therapy that followed. While not conclusive in itself, nevertheless it confirms that, far from being an isolating experience, VA therapy is a process which involves and may in turn encourage a therapeutic relationship. In doing so VA therapy adheres to Bruscia’s second criteria.

Finally – the musical experience itself – which is Bruschia’s third criteria.

Bruschia has shown great care and economy in his choice of words throughout his definition, and no more so than in his choice “musical experiences”. It is an all encompassing term which by definition includes both an active (playing) and receptive (listening) experience of music.
Clearly VA therapy offers a listening experience. It applies the fundamental principle that low frequencies have a relaxing effect and does so in a systematic way with the context of a therapeutic relationship. In this way VA therapy adheres to each of Bruschia’s criteria and is – music therapy.

**Postscript**

The paper was presented at the 5th European Music Therapy Congress. At the opening session of the Congress the delegates viewed a video entitled “Music Therapy in Europe”. It included contributions from present-day music therapists and from music therapy pioneers. The words of one pioneer proved to be particularly apposite in relation to this article. As Juliette Alvin spoke about music therapy she stressed that it was important to learn about how the body reacts to the vibrations of music “which affect our skin as well as it affects our perception”.

**Acknowledgements**

The author wishes to acknowledge the help of Martha Burke, Charles Butler, Kris Chesky, Byron Eakin and Tony Wigram.

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A longer version of the paper ‘An introduction to vibroacoustic therapy and an examination of its place in music therapy practice’ was published in 2001 by the British Journal of Music Therapy (15:2).

AUTHOR

JEFF HOOPER
SENIOR MUSIC THERAPIST
CRAIGMILL SKILL CENTRE
STRATHMARTINE HOSPITAL
DUNDEE
DD3 OPG
UK

Telephone: 01382-423000 Ext. 28153 0r 01382-528042
Fax: 01382-528043
Email: jeff.hooper@tpct.scot.nhs.uk
Jeff Hooper M.A., L.G.S.M.(M.T.), SRAsT(M) is a Senior Music Therapist working with Tayside Primary Care NHS Trust. He is based at Craigmill Skill Centre, Strathmartine Hospital, Dundee.

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The Dynamics of Arts Integration

By Enrico Giordano

“Meeting in the air” - An introduction by Petra Kern

On my way back from the PhD course at Aalborg University, Denmark, I met Enrico Giordano on flight SAS 909 to Newark, New York. When taking off, Enrico started to make sketches from the pictures that the aircraft’s video camera was broadcasting. My curiosity was great enough to ask him what he was doing. A friendly conversation got us into deep insights and a universal connection. Enrico Giordano is the Chairman of the Fine Arts Department at the College of Mt. St. Vinces, New York City. He is a visual artist as well as an Integrated Arts Specialist. In his studio, The Hudson River Arts and Design Center at the College of Mt. St. Vinces, he conducts workshops for teachers and children from the New York City public school districts to enhance classroom curriculums by fostering creativity in teachers and students. When Enrico talked about his ideas and visions, the bridge to music and music therapy in educational settings was easy to build. His attitude and the way he sees his work has much in common with our profession. As an Integrative Arts
Specialist, he uses the unique yet universal potential of arts to find new ways of educating children and to release deeply suppressed feelings. He guides the teachers and children to access their creative sources for learning and coping with difficult events. You will read in his article “The Dynamics of Arts Integration” why he includes drawing, painting, performing, poetry, music, rituals, environmental art, history and mythology in his workshop, and how he creates a holistic and open platform for academic, personal and community growth. Sharing our thoughts, dreams and visions on the flight was very inspiring. We came up with crazy ideas, hopes and dreams. What they will come to is still up in the air!

The Dynamics of Arts Integration

The creative process is a natural connection to how children learn. It is especially important for children who have difficulty with the more traditional paths of classroom curriculum. Because children play instinctively, they naturally connect to the creative process, which is one of the greatest examples of play—whether it be in visual art, performing art, music, science, mathematics, or literature/poetry. It follows that curriculum should include play—creativity. Not to include it cuts off one of the most fundamental ways of learning.
The Dynamics of Arts Integration

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FIGURE 1. Play 1
FIGURE 2. Play 2
One of the greatest fears or obstacles to Arts Integration that teachers face is their perception that one must be an art specialist, that one must be “talented” in order to have an arts presence in the classroom. They usually express this in statements like: “I’m not an artist, I can’t do this.” “I can’t draw and I don’t have any talent”. My response to these statements is: “most of you I assume, are not authors, yet you teach writing, you’re not mathematicians, yet you teach math, you’re not scientists, yet…etc.” I go on to remind them that they too, were once children, and like children, they have the innate capacity to play-creatively. Ultimately, Arts Integration is about the children; the teachers need not be proficient in art in order to “use it” in the classroom. They do however, need to under-
stand the importance of art for their students and the role it plays in enriching the curriculum, indeed the role it plays in enriching us all.

*Arts Integration*

New York City Public School teachers for the most part, have very little, if any, arts training. Consequently, the arts are either left out of a child's educational experience or they are relegated to the fringe of the school day. Public School (PS) 7, in the Bronx, exemplified this situation. With a population that is predominately minority immigrant based, students were having difficulty with the traditional curriculum. The leadership felt that the school environment—students, teachers, administration, and physical space—needed a change. They approached me, as chairman of the Fine Arts Department at the College of Mt. St. Vincent (with whom they have had a long-standing relationship) with a proposed grant application for the competitive Annenberg Foundation/Center for Arts Education Grant. The grant's objective was to significantly alter the school environment through the wider incorporation of the arts. In 1996 we were amongst a group of applicants which received this prestigious award. The success of the partnership is demonstrated by the fact that Annenberg extended our grant through 2003.

The project funded combines ideas generated by my work as a visual artist with those I have developed as an Integrated Arts Specialist—a new kind of arts educator created and established through my work. I use these ideas in teacher training workshops that are conducted at my studio, which is in “The Hudson River Arts and Design Center at the College of Mt. St. Vincent.”
FIGURE 4. Artworks 1

**FIGURE 5. Artworks 2**
FIGURE 6. Artworks 3
FIGURE 7. Artworks 4
FIGURE 8. Artworks 5
Arts Integration

FIGURE 9. Artworks 6
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The Dynamics of Arts Integration

FIGURE 10. Artworks 7
The goal is to integrate art into, and across, as many curriculum areas (literacy, math, science, social studies, etc.) and in as many New York City
public schools as possible. To achieve this goal, concepts developed in my paintings and multi-media art such as: transformation, metaphor, mythology, ritual, improvisation, architectonics, and “revisitation” are subsequently incorporate into teacher and staff development.

The essence of the methodology lies in the dynamic relationship between the creative process and the fostering of creativity in teachers and students. Because the ideas and techniques for these workshops evolve from my own studio work, they are inherently unique. To the best of my knowledge there is no other equivalent training.

The success of these concepts and methods is exemplified by the fact that their implementation at PS 7 has become a “model” of Arts Integration by Annenberg’s Center for Arts Education. They are promoted in the Center’s booklet “Promising Practices: The Arts and School Improvement,” New York, 2000. This work has also been documented by the French and German media; and was a focus in the Pedagogical University of Copenhagen’s April 2002 conference.

The Hudson River Arts and Design Center

Teacher training in Arts Integration begins at the Hudson River Arts and Design Center. Here teachers begin the process of transforming their own views about art and curriculum. The goal is to locate and activate the “dynamism” of the Arts Integrated teacher.
Through interdisciplinary arts workshops at the college, teachers explore the use of the arts across the curriculum as they break down boundaries and inhibitions. In the Arts Integrated environment of these workshops walls begin to slowly come down. Layers of experience are built upon in drawing, painting, performing, poetry, music, environmental art, history and mythology. The Arts Integrated teachers take these layers of experience back to the classroom where they are woven into the fabric of social
studies, natural science, math, and literacy. Art becomes the catalyst, the activator that transforms the entire school from principal to teacher, from student to the physical spaces themselves.

As one teacher wrote: “The professional development workshops at the College of Mount Saint Vincent do not offer formulas for Arts Integration. They do not transform classrooms into galleries that reflect curriculum. Instead, they give teachers the chance to transform themselves. They let teachers tell their own stories through the arts and give them the opportunity to become comfortable with art materials and techniques. Before long, the teachers can expect their self doubts and inhibitions to subside while the artist in them begins to emerge.” Although not intended, participants consistently maintain that these workshops are “therapeutic.”
Music Therapy Today (online), October, available at [http://musictherapyworld.net](http://musictherapyworld.net)

FIGURE 13. Teachers and Shadows 1
FIGURE 14. Teachers and Shadows 2
FIGURE 15. Teachers and Shadows 3

FIGURE 16. Teachers and Shadows 4

![Image of Teachers and Shadows 4](image-url)
Music Therapy Today (online), October, available at http://musictherapyworld.net

FIGURE 17. Teachers and Shadows 5
FIGURE 18. Teachers and Shadows 6

“Jaguar Visions” integrates the arts into the social-studies curriculum on Central and South America. It also examines the role of the shaman and visionary experience in native art. Students and teachers take turns playing the role of a Peruvian shaman, while others enter a darkened classroom “dressed as jaguars.” They move to the rhythm of Peruvian music. When directed, the music and the movement stop, and the “jag-
uars” whisper their visions into the shaman’s ear, such as “I see a big beautiful monarch butterfly” or “I see a colorful quetzal bird”, etc. These visions are then shared with and drawn by the class. Then, the symbiotic relationship between the shaman and the natural world, (the jaguar) is discussed and illustrated on the board with composite drawing techniques. Finally connections are made-- to natural science by focussing on the jaguar’s habitat as well as the flora and fauna of the region; to math with connections to geometric shape vocabulary; and of course to literacy with the creation of myths based on the visual work created.

FIGURE 19. Jaguar 1
Samples of Arts Integration Workshops

FIGURE 20. Jaguar 2
In “Movement and Sound: Living Sculptures” teachers create movement and sound as they move to the rhythmic beat of their colleagues who simulate the sounds of chisels carving stone monuments, by clapping stones together. Their movements simulate or express the evolution of sculptural form from inert stone to “living statue.” The slow movements of a teacher--hidden under a large white sheet (symbolic of a block
of white marble)—begin to take the shape of a statue. A sense of anticipation is generated, as another teacher becomes the sculptor, carving the work of art. The sheet is then removed from the form revealing the “finished statue.” Teachers then draw the pose and visually “dissect” the model, locating all of the geometric shapes that inform its movement. Clay models, based on sketches, are made and placed in front of a painted scene. Finally, connections are made to mathematics and literacy.

Samples of Arts Integration Workshops

FIGURE 22. Sculpture 1
Samples of Arts Integration Workshops

FIGURE 23. Sculpture 2
Samples of Arts Integration Workshops

The focus of another workshop is on **Improvisation and Refinement in Visual Art, Music, and Poetry**. Teachers listen to various musical styles responding simultaneously by painting and drawing various shapes and forms. They then respond to the visual material with poetic improvisations. The poems are edited and refined. Teachers then participate in brainstorming sessions designed to tailor the exercise to specific curricula. Next, teachers collaborate on a mural refining the initial drawings and paintings. The workshop concludes with a critique of the Arts Integration process.
9-11

I recently created a series of workshops for teachers and students that focused on the idea of the hero and rebuilding New York after 9/11. The intent was to integrate the topic into the social studies curriculum of New York, while keeping the focus on heroism. This was expanded to include the idea of monuments and public sculpture and new skyscraper designs, in and around the city. Of course the connection to current events was obvious, since much of the attention after 9/11 has centered on creating a monument or memorial of some kind and rebuilding the downtown skyline.

Searching for a theme, and a symbol that might consolidate and synthesize all that heroism implies, I found what I was looking for in the image of firefighters, which seemed everywhere; on posters, in magazines, newspapers, calendars, on TV, etc. A deeply moving photo in the New York Times, of a firefighter, resting on a pile of rubble, one hand covering his eyes, the other learning on his helmet, caught my eye.
FIGURE 25. Firefighter

It evoked the Greek archaic sculpture of an exhausted warrior who supports himself on the rim of his shield. In this case the helmet was the firefighter's “shield” -- as it supported his physical and emotional weight.
After seeing that photo (Figure 25 on page 32), I realized that the part of the firefighters uniform that was the most distinctive and emblematic, was the helmet. Structurally sound and visually connected to other forms—both man-made and natural— it became associated in my mind with heroism.
Evoking classical forms of architecture such as the ribbed vaults of Romanesque and Gothic churches and mosques, these damaged and scarred helmets became more sacred than the classical forms they recalled.
The helmet's shape, so married to form and function, in its role as protector of the head it serves, resonated as the image that “said it all.” It is the contemporary symbol of heroism. And, it synthesized the archetype and the specific simultaneously: crown, container, protector and scaled down architectural monument all in one.

From that day on, the workshop program entitled A Hero's Helmet: Monuments to New York City Firefighters became a part of my repertoire.
PART 1. A HERO’S HELMET: MONUMENTS TO NYC FIREFIGHTERS

1. Discussion and definitions: What constitutes a hero? What is a monument?
2. Movement and improvisation: Creating gestural poses of actions used by firefighters to save lives.
3. Demonstration of gesture drawing technique: Sketching the poses on the blackboard for students to observe, students pose, class sketches.
4. Placing each pose: each gestural monument drawing is placed on a pedestal, which is designed by the students.
THE ARCHITECTURE OF A FIREFIGHTER'S HELMET

FIGURE 30. Sketches II

1. Discussion and illustration: Why is the shape of the helmet a form of protection? Where else does this form exist in nature? Does it exist elsewhere?

2. Conceptual drawing/shapes of protection: Dome of the turtle shell, dome of a skull, dome of the nations capital, dome of firefighters' helmet.

3. Improvisation and performance: Students “become” the architectural forms of a rib vault dome to illustrate the distribution of weight and lateral tension. They experience the rib vault's ability to withstand those two forces. (The rib vault is seen in cathedrals, mosques, and
temples, and, of course, constitutes the dome of the firefighters' helmet.)

4. A hero's helmet monument designs: Students create designs for monuments to firefighters by cutting photographs of fire fighters' helmets into fragments and reassembling them in a collage, or they draw a large scale helmet on a pedestal and surround it with their gesture drawings of monuments and add color.
1. Discussion focuses on large photograph of important buildings in New York City for example: Empire State Building, Citicorp, Flat Iron, Chrysler, etc.

2. Students participate through drawing activities in an illustrated history of architecture from caves to skyscrapers.

3. How can we touch the sky and not leave the ground? The relationship between human form and architecture: Improvisation and drawing activities utilizing one to four students per group and arrange them in standing, kneeling, and sitting positions that echo shapes and structures found in skyscrapers.

4. A demonstration on the blackboard is given as to how to deconstruct the body and abstract it by using geometric shapes and forms in drawing techniques.

5. Designing original skyscrapers: students create their own original skyscraper design with pencil on paper utilizing concepts from above.

6. Reading and interpreting a poem by Langston Hughes entitled “Touching the Sky.”
Not only are these workshops designed to activate and concretize curriculum themes but also, and perhaps more importantly, they offer avenues for the students to express deeply suppressed feelings of anxiety over 9/11. These feelings and concerns have been the subject of recent studies published in the New York Times.

It is important to note that teachers are given follow up literacy activities with their classes such as creating poems about their skyscraper designs, writing stories about a hero's helmet, or fictional works about their monuments coming to life, etc.

During an Arts Integrated workshop at PS 85 in the Bronx, in which the above workshop was utilized, connections were made to the fourth grade social-studies curriculum on New York and current events. I looked over at several fourth graders working on a design for a “New World Trade Center site”. One of them was sobbing and being consoled by her friend. Her friend looked up and said, “she’s not crying because she can’t do the drawing, she’s crying because her aunt was on the plane that hit the World Trade Center.” Her drawing was wonderfully fanciful with whimsical designs of turrets, onion domes, pennants, and stained glass windows. A big bright orange sun shone in a blue sky, as a plane passed benevolently over the building.

Representatives of the Pedagogical University of Copenhagen, who were visiting Harvard University’s School of Education, were invited by the
New York City Board of Education to visit PS 7 to observe an Arts Integration Program. They were excited by what they experienced and accepted an invitation to participate in a workshop at the Hudson River Arts and Design Center. After seeing the success of my theories and programs, they invited me to go to Denmark. The objective of the visit was to co-present at a conference for Danish educators that would introduce them to the ideas and techniques of Art Integration. The co-presenter at the conference was Julie Viens, representing Harvard University’s Howard Gardener’s theory of Multiple Intelligence. (This theory basically stipulates that there are different types of intelligence thus different ways of learning; effective teaching should therefore teach to these different types of intelligence.)

Before the conference Viens and I discussed how we would incorporate Gardener’s theories with my notion of Arts Integration. We agreed that we would divide the workshops into different groups and would rotate the participants so that they would all experience the different approaches to learning. The conference concluded with a combined session in which Viens and I presented our views as to how the two approaches could combine to create a richer learning experience for student and teacher. At the conference’s conclusion, organizers and participants enthusiastically maintained that this was one of the “most successful conferences given by the University.”

A projected image of an Iroquois False-Face Mask hovered across the distinctly Scandinavian Gothic Ceiling of the Ceremonial Hall of the University.
The mask color, a reddish brown, blended into the oak wood panel ceiling—as if carved from that very wood. Below, a “beach shoreline” had been created on the floor with shells, sand, seaweed, refuse, and driftwood. Native American music greeted the conference participants. Two rows of thirty to forty teachers filed down the center isle and lined up on either side of the “beach installation”.

FIGURE 33. Iroquois mask
The participants slowly began, one by one in soft, gentle voices, to read the poems they had created as part of a previous workshop. As they rounded the beach they were instructed to gradually increase the volume and intensity of their voices. So at the third go-round, they turned and faced one-another and were by this time, shouting their “Poems of Power.” The words were transformed into a cacophony of sounds, and the Ceremonial Hall became an acoustical chamber! A cathartic feeling gripped both the audience and performers, as a round of applause spontaneously burst forth from the conference participants.

Figure 34. Teacher masks
Next, the poems were transformed into the visual expressions of their power through collage and mask designs. Participants then explained, to one another, how their images were created from their poems. Finally, Veins demonstrated how the workshop enabled the participants to use their different types of intelligence. This inductive process illustrated how the arts were connected to literacy and social studies, more specifically the relationship between Native American culture and nature.

*It’s About the Children*

Arts Integration is not concerned with transforming teachers into artists or art specialists. However, the ideas and methods do focus on raising the teachers' comfort level with the creative process. They are about transforming teachers' perceptions of what constitutes art making, as well as deconstructing their preconceived notions of what art is. Changing or expanding teachers' expectations of student work, and what constitutes quality, is another important component. Finally, and perhaps most importantly, Arts Integration teachers are taught to connect the Arts to large or universal themes in their curriculum. For example, the theme of “transformation” can be found virtually everywhere, in science, literature, social studies, or math. This process is fundamental to successful Arts Integration. Thus the Arts Integrated teacher becomes aware of the ubiquitous nature of the Arts-- their presence in virtually everything that we do and in every curriculum area taught.

Ultimately, Arts Integration is about the children, our students. It’s about giving teachers access to the child within. So that they can connect to their own creativity and enhance classroom curriculum by speaking to...
their children in a language that is innately theirs—the language of play and creativity.

FIGURE 35. Transformation 1

FIGURE 36. Transformation 2
Figure 37. Transformation 3

ADDRESS: Professor Enrico Giordano, Chairman, Fine Arts Department, College of Mt. St. Vincent, 6301, Riverdale Ave., Bronx, N.Y. 10471, USA egiordan@mountsaintvincent.edu

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Therapeutic methods of experienced music therapists as a function of the kind of clients and the goals of therapy

Klaus Drieschner and Almut Pioch

Abstract

This article centers on the variety of therapeutic approaches and questions the idea that a certain music therapy tradition and training is based on the practice of teaching and trading their methods. Moreover, it shows that the methods of a certain approach were developed from the kind of clients and specific situated goals and actions of therapy. This geopsychology-like approach reminds us, that we should not only look at the founders and persons, who developed a certain approach and practice, but to regard their ecological situation and performance during the time of development.

The authors focused on questions of receptive and active methods, problem-focussed and music-focussed approaches and scheduling levels of structuring for the therapeutic practice of 30 experienced therapists were elaborated and researched. Their conclusion:"This study has shown that these dimensions are not merely theoretical constructs but also exist in the clinical reality. ... The results suggest that the ego-strength of clients can explain a lot of the methodological variation. However, there is definitely no general agreement about the choice of methods. The statistical analysis showed that the goal of therapy and the target group together account for 25 –50 % of the differences between therapeutic methods on the three dimensions. This means that factors such as the theoretical frames of reference of the therapist, differences in
professional socialisation, personal preferences etcetera, may be at least as important for the choice of method”.

Having presented this for the first time at the 2001 EMTC conference in Naples, we would like to share with you the emergence of this important empirical study into the real world of applied music therapy. (JF)

**Introduction**

An international conference like this reminds us that “music therapy” is a collective term for a huge variety of therapeutic methods. The situation is sometimes confusing, even for us, let alone for outsiders, such as other health care professionals, clients, health care managers, or the general public. A definition of music therapy (and there are many) only sets the common ground of our profession. It does not guarantee a strong professional identity, as little, for example, as definition of the European border automatically leads to a European integration process.

Let me stick to this metaphor for a moment. Today, it has generally been accepted that the integration of Europe requires the recognition of regional identities. The idea is that acceptance of the differences between the parts will lead to an integrated whole. This seemingly contradictory idea may also be true for music therapy: In order to get a strong professional identity, *we have to find out in which way the methods of music therapy differ*. This is our first research question. It may seem paradox, but as you will see, a systematic look at the differences between methods automatically opens the eyes for what they have in common.

Once we know in which way methods of music therapy differ, we should ask whether the methodological pluralism makes sense from the point of view of the client. Of course, different problems of clients require differ-
Therapeutic methods of experienced music therapists as a function of the kind of clients and the goals of therapy

Therapeutic methods of experienced music therapists as a function of the kind of clients and the goals of therapy

Method

How did we try to answer the two research questions? We conducted intensive standardized interviews with 30 registered music therapists working in adult psychiatry, geriatrics, child psychiatry, or the care for the mentally handicapped. They had an average experience of 14.5 years.

The focus of the interview was on the therapeutic methods, the respondents implemented during their workweek. In this study, the term “method” refers to the actual in-session behaviour of the therapist as it is experienced by the client and not to background variables such as the theoretical assumptions, goals, and the like. Together the 30 therapists used 140 methods. 13 methods had a purely diagnostic purpose and are left out of the analysis presented in the following. There were about as many methods for individual music therapy as for group therapy.

The interview contained 20 questions with which the position of each method on the three dimensions was assessed.
The conceptually most simple dimension was the well-known distinction between receptive and active music therapy. That means, listening to music or actively making music as core element of the method. Methods with both, active and receptive elements lay in between.

The second dimension, "focus of attention", has to do with the function of music in the method. In some methods the relevance of the music or activity for the client’s problem is discussed explicitly. We call these methods “problem-focused” because the client’s attention is drawn to the impact of the music activities on his problem. In other methods, the therapeutic process is presumed to take place within the music or activity itself, without explicitly focusing on the relevance for the problem of the client. Such methods we call “music-focused”. This dimension is similar to the well-known distinction between ‘music as therapy’ and ‘music in therapy’.

The third dimension we called "level of structuring". The term ‘structuring’ refers to all activities with which the therapist limits the behavioural freedom of the client. Structuring includes things such as ‘determining the kind of activity’, or ‘giving specific instructions’, ‘choosing the music or the instruments’, etcetera. The dimension ‘level of structuring’ includes the concept of directivity but is a broader concept.

We believe that most differences between methods, defined in terms of actual, observable therapeutic behaviour, can be located in one of these three dimensions. Now, we can conceptualise methods of music therapy within a three-dimensional space (see Figure 1 on page 5).
A few examples: In the corner at the front – bottom – left, you would find music therapy with free improvisations as core element, which are explicitly discussed in terms of relevance for the client’s problem. At the rear – top – left, you find a method like Guided Imagery and Music (GIM): a receptive method, highly structured by the therapist, and with an explicit focus on the client’s problem. At the front – right – top, you would find a method like making pop-music with delinquents with the aim of enhancing empathy, endurance, and self-esteem. The clients’ attention is on the musical process, the intended therapeutic effects are assumed to result directly from the activity itself. At the vertical edge in

FIGURE 1. Three dimensional space of music therapy methods

the rear –right, you find music therapy for Alzheimer patients, in which listening to familiar music is used to enhance the sense of identity or to reduce agitation. Depending on whether the client chooses the music by himself, the method receives its position on the dimension ‘level of structuring’. If listening is combined with singing, the method shifts towards the front.

Apart from three dimensions, we inquired about the presumed importance of four different therapeutic mechanisms in each method:

- The effect of the *music by itself*. This factor includes the potential of music to enhance relaxation, to activate emotions, to evoke memories or to induce physiological changes.
- Secondly, effects resulting from the *music-activities*, that is the interaction of the client with the music material. This mechanism may be linked to effects such as increasing expressiveness, enhancing self-control, etc.
- Thirdly, the “*therapeutic relationship*”, which is generally regarded as an important therapeutic factor.
- And finally, the factor “*insight*”, that is effects resulting from a better understanding one’s own personal or social functioning.

If music therapy is conceptualised as an interaction between client, therapist, and the music or music material (see Figure 2 on page 7), the four factors emphasise different aspects of this interaction.
FIGURE 2. **Four therapeutic mechanisms as interactions between therapist, client and music**

Mechanism A is located at the music-corner as the effects are presumed to result directly from the music itself. Mechanism B is an interaction of the client with the music or material, which, of course may be facilitated by the therapist. Mechanism C is an interaction between client and therapist, mediated by the music. Mechanism D refers to cognitive-emotional processes within the client, facilitated by the therapist and the music or material.
3. Results

3.1 RESULTS CONCERNING THE FIRST RESEARCH QUESTION

The results of the statistical analysis provided evidence that the three dimensions are a valid concept for the conceptualisation of differences between methods of music therapy.

First, a principal component analysis with orthogonal rotation perfectly supported the dimensions ‘active versus receptive’ and ‘focus of attention’. The factor ‘level of structuring’ might consist of two sub-dimensions. Secondly, the three dimensions were found to be more or less independent from each other. Only the dimensions ‘focus of attention’ and ‘level of structuring’ correlate moderately (.35). Methods with more music focus tend to be more structured than methods with problem focus. Thirdly, the scales for the three dimensions have a very satisfactory reliability (Cronbach’s alphas between .84 and .89).

3.2 RESULTS CONCERNING THE SECOND RESEARCH QUESTION

Does the kind of method depend on the category of patients and the goals of therapy?

For the statistical analysis we distinguished between six categories of patients: geriatric patients, most of whom suffering from a form of dementia; children with various kinds of psychopathology; mentally handicapped patients with various problems; adults with neurotic or personality problems; adults with depression of anxiety; and psychotic patients. Unfortunately, we could only distinguish different adult categories, because splitting the other groups would have resulted in too small numbers of methods for the statistical analysis.
3. Results

As Figure 3 on page 9 shows, methods for each target-group have a specific pattern on the three dimensions. This means that on average the therapeutic methods with different kinds of patients are positioned at different locations within the cube shown in Figure 1 on page 5.

If we look specifically at the dimension ‘receptive – active’ (the rhombuses), we see that receptive methods are most common with the elderly.
and with depressive adults. They are rare in therapies with neurotic adults and with children.

On the dimension ‘focus of attention’ (the triangles), we see a strong music focus in the therapies with the mentally handicapped. In contrast, in therapies with neurotic or personality disordered adults it seems far more common to draw the clients’ attention explicitly to the therapeutic meaning of the music activities.

The level of structuring (the rectangles) is lower in music therapy with non-psychotic adults than with any other target-group. This dimension seems to be a function of the ego-strength of clients. It seems as if the structure provided by the therapist compensates for the lack of structuring capacities of the clients.

Are there also systematic differences between methods for different goals of therapy? For this analysis, we used five categories of goal, which had been used in earlier research in the Netherlands:

**SUPPORTIVE GOALS**

- Structuring, which includes limiting the negative impact of the problem
  - Focal behaviour-change or symptom-reduction
  - Enhancing problem-related insight
  - Enhancing general insight and personality change

Notice that the five categories form one dimension from more superficial goals, to goals with a more profound impact on the patient.
3. Results

Figure 4 on page 11 shows that, like in Figure 3 on page 9, the methods for each kind of goals have their own pattern, which again corresponds to different positions in the cube. Only the methods which aim at the two different kinds of insight have a similar pattern, which is more pronounced if a deeper and more general insight is intended.

If we look at the three dimensions separately, we see that in general, with more far-reaching goals, methods become more active and less receptive (see the rhombuses), they become more problem-focused and less music-focused (see the triangles) and they become less structured (see the rectangles).
3. Results

These results can again partly be interpreted in terms of ego-strength. Goals with a profound impact of the patients are more common for patients with considerable ego strength. Therefore less structure and a more explicit focus on the therapeutic relevance of the activities may be possible in therapies with these kinds of goals.

Two MANOVA showed that the category of patients and the goal of therapy both make a statistically significant difference for the three dimensions (p<.01). Univariate ANOVA’s for each of the three dimensions were all significant at the .05 level except one. There was only a trend for the influence of the goals of therapy on the dimension ‘focus of attention’ (p=.69).

What about the presumed therapeutic mechanisms? Figure 5 on page 13 shows differences in therapeutic mechanisms in therapies with different categories of patients. (A higher position of the symbol means that the mechanism is on average considered more important in the methods for the respective category of patients).
3. Results

The factor insight (the white triangle) is considered most important in therapies with neurotic or personality disordered adults. In contrast, it is considered especially unimportant with the elderly or with mentally handicapped clients. The opposite is true for the therapeutic impact of the music by itself (the black rectangle). This factor is regarded as important for elderly or mentally handicapped clients but as unimportant for neurotic and personality disordered adults. Interesting is also the important role of the therapeutic relationship in therapies with psychotic adults (black rectangle).
The importance of the four therapeutic factors also clearly varies with the kind of therapy goals, as the next figure shows.

The importance of the music by itself (see the black rectangles) seems to decrease, while the importance of the factor insight (white triangles) increases when goals of therapy become more far-reaching. Of course, it is not surprising that insight is considered more important, when insight is the general goal of therapy. More remarkable is the importance of the interaction with the music material (white rectangles) in therapies aimed at general insight. This suggests that insight does not primarily result from verbal interventions but also from musical experiences. It is also interesting that the presumed importance of the therapeutic relationship seems not to depend much on the kind of therapy goal.
Again two MANOVA’s showed that both, the category of clients and the goal of therapy, made a difference for the presumed therapeutic mechanism of methods (p <.01). Furthermore, univariate ANOVA’s were significant for the ‘music itself’ and ‘insight’, for the influence of the category of clients on the importance of the therapeutic relationship and for the influence of the goal of therapy on the importance of the interaction patient – music/material (all p<.05).

**Conclusion**

What can be concluded regarding the second research question? In general, there seems to be some consensus among experienced music therapists, which general type of methods have to be used for certain categories of clients and goals of therapy. The results suggest that the ego-strength of clients can explain a lot of the methodological variation. However, there is definitely no general agreement about the choice of methods. The statistical analysis showed that the goal of therapy and the target group together account for 25 –50 % of the differences between therapeutic methods on the three dimensions. This means that factors such as the theoretical frames of reference of the therapist, differences in professional socialisation, personal preferences etcetera, may be at least as important for the choice of method. As these are certainly irrelevant factors from the point of view of the client, we would like to see their influence reduced.

What can be the impact of this study? As mentioned earlier, we believe that a systematic look at the differences between methods of music therapy opens the eyes for what methods have in common. For example, a Chinese choir of eighty psychiatric patients, a Nordoff-Robbins therapy,
and a vibro-acoustic treatment are so different that it is hard to perceive them as products of the same profession. However, they can conceptually be linked together with the three dimensions ‘receptive-active’, ‘focus of attention’ and ‘level of structuring’.

Furthermore, this study has shown that these dimensions are not merely theoretical constructs but also exist in the clinical reality. Therefore, we believe that they can support the development of a strong and international professional identity of music therapy.

In addition, the study can be used for a completely different purpose. If experienced music therapists with very different theoretical and educational backgrounds, independent from each other, make similar choices regarding therapeutic methods, this can be seen as representing a kind of implicit methodological knowledge. This implicit knowledge is probably based on a common experience of which methods are most effective in certain situations. If what methods of experienced therapists have in common is not only common practice, but also good practice, the results of this study are not only a description of the reality, but can also be used prescriptively, as a standard.

For example, if music therapists implicitly agree that receptive methods of music therapy are useful for the treatment of depressed adults, this implicit knowledge could be used for the development of specific methods for this category of patients or for the training of music therapists. At the very least, it can serve as a worthwhile hypothesis for outcome research.

From an international point of view, it would be interesting to find out whether the results from this study hold for other countries as well. This
would be evidence that our conclusions represent a kind of universal methodological knowledge and not only the Dutch reality.

ADDRESS:

Klaus Drieschner
music therapist and research psychologist

Almut Pioch
music therapist

K.drieschner@wolmail.nl
Reiderlandlaan1
9727 DR Groningen
The Netherlands

Here is the newest issue of music therapy today!

It is December now and I wish you all seasonal greetings!

I am happy to present another edition of our online magazine. We can use such a publication for sharing ideas, for reading about them and now - listening to them! With this issue we are introducing what we hope will be a stream of songs and instrumental themes that have been used in therapy. The first music “Meditation” comes from David and Lucanne recorded during a therapy session. It is a beautiful song and ambience of two guitars and voices performed when David was working together with Lucanne in New York this Spring. For those of you who have a favourite passage, or a whole piece of music, from therapy then send it to us. However, you have to be sure about the copyright issues and obtain permission from the performers, that also includes the patient if they are active. Like all the articles that are published here, copyright remains with you the author or composer. For listeners, it may take time to download, depending upon the internet connection that you have, because it is a 16 minute piece of music. However, the main benefit of electronic media is that we can publish writings about music therapy with examples that you can listen to, and soon video examples that you can download and watch.

The first article in this December issue is from Lucanne Magill “Music Therapy in Spirituality”. This is the response she gave to the Reverend Michael Mayne’s keynote speech at the world conference for music therapy in Oxford 2002. The article includes the “Meditation” above as a chant intended to soothe and comfort a dying patient. “When we went to her room, her son and friend were in far corners of her room. My colleague and I sat down next to her and asked her “What music would
help today?” She said: “I want to be in peace”.

Listening to music therapy is different from talking about what is heard in therapy. Furthermore, we also interpret what we have heard as it applies to the therapeutic process. David and Gudrun Aldridge propose a hermeneutic research method, which they call “Therapeutic narrative analysis: A methodological proposal for the interpretation of music therapy traces.”

The word “traces” here as a general term referring to the material left behind as an indicator that something has happened. These traces are empirical data. How these events are described and interpreted, as therapeutic process is the stuff of methodology. The interpretative process in qualitative research is referred to as hermeneutics. What we have in this paper is a suitable methodology for eliciting understandings and how such understandings are constructed. In the process of interpretation there are varying stages of abstraction, and they use differing sets of meanings. By combining a constructivist approach with a communications perspective, meanings are chained together to understand the therapeutic process.

The next article comes from Edith Lecourt “Music therapy research at University Renè Decartes Paris V”. Edith Lecourt’s pioneering work has made an enormous impact on the development of music therapy practice and research in France. In this article she gives insights into her experiences and describes problems of researching music therapy from a historical and methodological perspective. “It took a long time to promote music therapy from clinical practice to the level of research within the music therapy field. And it took as much effort to gain the recognition of this topic on an Academic level. On the theoretical level, we will observe how our psychoanalytical background paradoxically (?) helped the recognition of music therapy research in our country.”

The next article, a conference report, provides an actual insight into the different works done by doctoral students presenting their research work in a “Research Showcase” at Witten/Herdecke University in
September 2002. The presentations not only focus on music therapy research, some also research or art therapy or alternative healing methods but most common to them is a contemporary use of flexible research methods. The methodology should be suitable to the research question. Methodology is no ideology, but a tool to answer the question.

For other research institutions, maybe you would like to consider profiling the research taking place at your institute as a contribution to the magazine? Watch out for our forthcoming ONLINE RESEARCH REGISTER where you can let others know about what you are researching and see other what other colleagues are also doing. This will give you the chance to network with other researchers and practitioners.

Another qualitative research work is presented from a project on the use of Gong in music therapy setting. This article “Was am Gongklang bewirkt welche Erfahrung beim Hörer? Musikpsychologische Details aus einer qualitativen Studie” is presented in German. This qualified original work presented from the young researchers Christoph Wagner and Anna Koerting, supervised by Henrik Jungaberle from University Heidelberg is opening up another stream in our journal; providing the opportunity to publish work of promising young researchers and students who show a potential for a scientific way of thinking.

“Music Therapy Today” welcomes contributions from other people writing in languages other than english. English remains our main language for promoting international understanding. I am writing this to encourage all of you who want to contribute to our journal to send their work in their own language but you will need to provide an English abstract.

Once more seasonal greetings and a happy new year,

Until we read again

Joerg Fachner
Music Therapy in Spirituality

Lucanne Magill

This is the response that Lucanne Magill gave to Michael Mayne at the 9th World Congress of Music Therapy in Oxford, UK, July 26, 2002.

Abstract

In four themes in music therapy, we see the power of music to build relationship, enhance remembrance, be a voice to prayer and instill peace. As music therapists we are presented with the challenge and the opportunity to define, describe and verify what we do. This is an important task that we must do. It is also important for us to remember something that we all know; that it is in the lived moments of music therapy, when, as Michael Mayne says, the whole being, body, mind and spirit, is in the presence of music, when transformations begin to occur and healing begins, that it is in the lived moments of music therapy that the essence of our work—music therapy, spirituality and healing—is experienced and known.
Today, I would like to reflect with you on what I believe is really the heart of what we do, music therapy in spirituality. So much of what we do is beyond words and it is really because of this transcendental nature of music that important healing in music therapy can and does occur.

In my work as music therapist I have observed the difficult impact of metastatic illness: the pain, suffering, loss of self identity, loss of sense of meaning and purpose in life, loss of hope and loss of control. I have also observed the meaningful effects of music to restore, refresh and create union.

I would like to share with you my work since, as we all know, it really is in the lived moments of music therapy, when the human being, as Michael Mayne has explained, as body, mind and spirit, is merged with music, that the essence of music therapy and spirituality is seen, felt and understood.

In my work there are four recurring themes. There are many others as well, though these four are prominent.

**Relationship**

The first theme is *relationship*. Patients and families contending with life threatening illness or with the end-of-life, often feel out of touch with self and others. The self-identity may be challenged, they may be depressed, withdrawn, isolated or separated for sometimes long periods of time. Music reaches beyond words and bodily touch, builds bridges of communication and helps people be back in touch with self and others.
Example: Emanuella, age 78, was an Afro-American woman with an advanced brain tumor. She was depressed and withdrawn and was observed to be sitting in her room staring at the wall for long periods of time, not speaking to staff. A nurse asked me to go in to try to make contact with her.

(the therapist then plays a recorded example from the first session of music therapy singing “He’s Got the Whole World”)

After this session, she burst into this song whenever anyone, eg. nurses doctors, housekeepers, the music therapist, walked into the room. Two weeks later, she had deteriorated and was described as being in a semi-comatose state. She was for the most part non-responsive. I sat down next to her and sang this same song again. This is a recording of that session.

(The therapist then plays a recording of “He’s Got the Whole World” as it was sung in this session).

This example shows the use of a simple song, one that inherently describes contact with others and contact with the higher power, to build bridges of communication, reduce isolation and reestablish relationship.

Remembrance

The second theme is remembrance. During times of pain and loss, people are often driven back to times of comfort, security, predictability, or even of hardships. There is a natural tendency to review one’s life. The link between music and memory is strong, as we all know, and enhances this process.

Example: Janet, age 65, had a brain tumor that was progressing rapidly. She had disease-related aphasia and was very agitated due to her lack of ability to communicate. Her son, who was with
her most of the time, was very sad and frustrated. When I walked into her room, I showed her the songbook. She indicated, by pointing, “Danny Boy”. I sat down next to her and encouraged her to try to sing with me. I kept a gently firm rhythm to help engage her. I also paused between the first and second verses, to offer her the choice to sing the verse that talks about death and dying.

(A recorded example of Janet singing the words to “Danny Boy” is played. Janet chooses to sing the second verse too).

This is an example of the use of a familiar song to support remembrance. Janet chose a song that was important to her in her life. She remembered the words and was able to sing them in her aphasia. She also had the opportunity to say words about death and dying. She was in touch with times of closeness with her son, who seemed to have relief in hearing her verbalize in song again.

Prayer

The third theme is prayer. Patients and family members often have a need and desire to call out for relief from anguish, pain or sorrow. I mean prayer in a broader sense of the word, since it may or may not be in a religious context, but a calling from the deeper corners of heart, mind, and spirit. Sometimes this need to express is suppressed. Music reaches and is a voice.

Example: Wendell, age 45, was from the West Indies. He had been in the hospital for one month prior to referral to music therapy. He was not responding to the rigorous treatments for his acute leukemia. He knew he was getting sicker, not better. He was immersed in his TV, communicating very little. He was referred by his nurse, with her hope that music therapy would help him begin to express.
I went into his room and sat with him with his TV, to begin a dialogue. He gradually began to focus more and more on the topic of music and then said that he really wanted to sing “Fly Away Home”. This song was brought to him and we sang it together frequently, at his request.

(A recording of Wendell, Brenden -music therapy intern - and me singing “Fly Away Home” is played)

Following this, Wendell began to engage himself more with others and also talked about his faith at length. This is an example of how a patient can use a song to talk about his finality and express his faith and hope for the ability to “fly away home”.

Peace

The fourth theme is **peace**. Patients often long for comfort, relief from pain, peace of mind, relief from interruptions, uncertainties and relief from lack of control. As Michael Mayne so beautifully explained, music can calm and bring a sense of balance and order.

*Example*: Lois, age 68, had metastatic cervical cancer and was receiving palliative care for her difficult to manage pain. She was agitated and angry. She was referred by a doctor who requested music therapy to help her with her pain and agitation. When we went to her room, her son and friend were in far corners of her room. They ran up to us and requested “Flamenco” music. My colleague and I sat down next to her and asked her “what music would help her today?”. She said: “I want to be in peace”.

(An example of a meditative chant used in this session I played to reflect the words and needs of the patient).
At the end of the music, the patient said: “I am in beauty, I am in peace”. The music also had a calming effect on the family. In time we began to involve them in the sessions.

In these four themes in music therapy, we see the power of music to build relationship, enhance remembrance, be a voice to prayer and instill peace. As music therapists we are presented with the challenge and the opportunity to define, describe and verify what we do. This is an important task that we must do. It is also important for us to remember something that we all know, that it is in the lived moments of music therapy, when, as Michael Mayne says, the whole being, body, mind and spirit, is in the presence of music, when transformations begin to occur and healing begins, that it is in the lived moments of music therapy that the essence of our work—music therapy, spirituality and healing—is experienced and known.

I would like to end with the words of a patient who had many music therapy sessions and was dying of leukemia:

“\textit{When I am in the presence of music, I hear the voice of God};
\textit{When I am in the presence of music, I fly like a bird};
\textit{When I am in the presence of music, my spirit is free and I am in peace}.”

Lucanne Magill,
Integrated Medicine Service,
Memorial Sloan Kettering Cancer Center,
1275 York Avenue, New York, NY 10021 USA
Forschungssymposium

David Aldridge
Rhoda Born
Claudia Dill-Schmölders
Elisabeth Friedrichs
Simon Gilbertson
Harald Gruber
Ansgar Herkenrath
Peter Hoffmann
Monika Jungblut
Petra Kern
Martin Kusatz
Bärbel Reckhardt
Anke Scheel-Sailer
Wolfgang Schmid

Institut für Musiktherapie
Lehrstuhl für Qualitative Forschung in der Medizin
David Aldridge

Abstract

*In the University Witten/Herdecke on the 27th and 28th September, 2002 we held a Research Showcase with a selection of doctoral candidates at the Chair for Qualitative Research in Medicine. These are all candidates supervised by David Aldridge.*

It is hoped that you will see by the topics mentioned below the variety of work that is taking place at this Chair and stimulate other researchers to contact us with further research ideas with the intention of cooperating with our Institute and eventually submitting a piece of academic research.

There were two main purposes to the symposium. The first was for the presenters to practice making a presentation before an audience of interested practitioners. The second was that the audience themselves would be inspired by exciting ideas relevant to their own practice presented by practitioners like themselves. Twelve of the people making presentations are working as everyday practitioners and all base their work in clinical practice.

Presenters talked about different research topics surrounding the practice of music and art therapy and complementary medicine.
Friday, 27. September 2002

13.00 – 13.45hr. David Aldridge welcomed the delegates, in particular professors Tony Wigram from the University of Aalborg in Denmark and Professor Denise Grocke for the University of Melbourne in Australia. We have cooperative links to both Universities through our doctoral programs.

We have currently embarked upon a systematic review of the music therapy literature and compiling an online database of music therapy articles, an online music therapy research register and online evaluation tools for evaluating quantitative and qualitative research designs linked to expert opinion. Instead of using the terms “quantitative and qualitative”, we are now using “fixed and flexible” research designs.

13.45 – 14.30 hr. Simon Gilbertson reported on his planned survey of music therapy in the practice of neurosurgical rehabilitation throughout Europe. He demonstrated how searching the literature is fraught with problems when scrutinising the major published databases. He concludes that it is necessary to have a carefully thought out search strategy.

14.30 – 15.15 hr. Monika Jungblut spoke of her pioneering work “Music Therapy with Aphasic Patients in the late Rehabilitation – The Development of an Integrated Treatment. This is a small scale matched-control study of patients suffering with chronic aphasia. Her preliminary findings are that there is an improvement in the expressive capabilities following treatment compared to a no-treatment control group. The improvement in spontaneous speech is seen to have a positive influence on everyday communication.

16.00 – 16.45 hr. Wolfgang Schmid presented his current studies on Music Therapy with People suffering from Multiple Sclerosis. This too is a matched-control study of multiple sclerosis patients. Music therapy is the treatment being offered. the second part of his study is a qualitative assessment of what happens in the music therapy sessions. To this end he is using videotaped examples of material and the Therapeutic Narrative Analysis approach (see article from David Aldridge, this issue).

16.45 – 17.30 hr. Ansgar Herkenrath reported his work on with patients in a persistent vegetative state as “Meetings with the consciousness of patients in a persistent vegetative state”. He raises questions about the prevalent views that such patients are not aware of their surroundings and through a series of videotaped examples show how musical contact is achieved. He is also using videotaped examples of material and the Therapeutic Narra-

tive Analysis approach.

17.30 – 18.15 hr. Claudia Dill-Schmölders reported on her work with patients suffering with Parkinson’s disease. Music therapy offers a clear approach to improving gait through the rhythmical properties of music.

Saturday 28th. September 2002

9.00 – 9.45 hr. Elisabeth Friedrichs, a medical practitioner, is using a Traditional Chinese Medicine in Bavaria. Her study “Qigong Yangsheng as a Prophylactic Treatment of Migraine and Headache” is the third in a series of QiGong Yangsheng studies here at the Chair of Qualitative Research in Medicine.

9.45 – 10.30 hr. Anke Scheel-Sailer, also a medical practitioner asks the question “What therapeutic influences do the arts therapies have in the first stages in the management of paraplegic and quadriplegic patients”? Her work was carried out at the anthroposophical hospital in Herdecke. She followed the progress of all the patients on a hospital ward and analysed their medical notes, their art therapy products, patients and therapist reports from her perspective as the treating physician.

11.00 – 11.45 hr. Bärbel Reckhardt, a medical practitioner working in the same hospital, looks at “The influence of Eurhythm and basal Stimulation on breathing, heart rate and oxygen saturation in healthy new-borns”. Her work demonstrates that there is a positive influence.

11.45 – 12.30 hr. Martin Kusatz has developed his own integrated approach to music therapy - The Krefeld Model - and in a survey design has discovered that not only do sufferers respond favourably and positively to his approach irrespective of how severe the tinnitus is or how long they have suffered prior to therapy.

14.00 – 14.45 hr. Peter Hoffmann, as music therapist, supervisor and teacher, is concluding his doctoral thesis and presented part of his study “Phrasing, phrases and phrase mongers” A study of phrasing in music therapy. He uses a qualitative approach and validates his use of the clinical term “phrasing” by submitting examples to a panel of expert assessors.

14.45 – 15.30 hr. Petra Kern, a German music therapist practising in the United States is studying “Using music therapy with teachers and caretakers for the integration of young children with autism in child care centers”. Her work has already found acceptance within the early education community in the United States and demonstrates how music therapy can be integrated into community settings, particularly those of early education.
This takes music therapy out of the clinical situation and relocates it into an educational setting. As she is also finding, it is not simply the children, teachers and helpers that use this music, it is also transported to the families and friends of the children. The research design is a series of single case designs that contribute to an overall case design approach.

16.00 – 16.45 hr. Rhoda Born, an art therapist, has almost completed her study of “The competent patients: the subjective perception of patients during their clinical process”. This qualitative study is based on the analysis of transcribed patient interviews. The impressive result is that a theory emerges about successful patient progress and connection to the art therapy process.

16.45 – 17.30 hr. Harald Gruber, also an art therapist, is examining how art therapy experts reach their assessment of spontaneous pictures made by people suffering with cancer.

Contact address: Christina Wagner
cwagner@uni-wh.de
Secretary to the Chair of Qualitative Research in Medicine, Professor Dr. phil. David Aldridge
Music Therapy Research
At University René Descartes - Paris V -
Which Sorts Of Satisfactions Are Given, Produced, Through Music Therapy?

Edith Lecourt

Abstract

This is a general presentation of the development of music therapy research at University.

It took a long time to promote music therapy from clinical practice to the level of research within the music therapy field. And it took as much effort to gain the recognition of this topic on an Academic level. At this moment the institutional aspect is essential. We will develop this point and be attentive and interested to participants’ experiences on this level. These last years music therapy research became a “natural” topic in Academic selection in clinical psychology, whereas in musicology the situation is progressively changing in some Departments.

In the second part of the presentation we will emphasize the specificity of music therapy in the analysis of patients’ sonorous/musical productions, the importance given to audio or/and video analysis, and the necessity of developing new tools for research. On the theoretical leveller will observe how our psychoanalytical background paradoxically (?) helped the recognition of music therapy research in our country. Finally we will present a panel of the actual situation, of the main topics, the recent completed researches and the projects in progress.
It took a long time to promote music therapy from clinical practice to the level of research within the music therapy field.

In France, clinical applications were officially developed in psychiatry thanks to Dr. Philippe Pinel, the founder of the psychiatry, followed by his disciples, since the very beginning of the nineteenth century. It was both receptive and active music therapy. This author considered that this use of music participated to create a link between the subjectivity of the patient (his story) and the social world: music therapy was a tool of recovering and rehabilitation.

It seems that it took more time to develop experiments in music pedagogy for handicapped: even if the name of this teacher of keyboard, in the early twentieths, Henriette Lafarge (1936), did not become famous as many others did. I consider indeed her first experiment with her handicapped daughter - and its development with clients - as still very relevant: playing keyboard with the child’s hands inside the musician’s hands in a corporal relationship, introducing by the touch and the movements of hands and fingers to classical pieces of music, their gestalt and interpretation, instead of technical exercises. This created a very profound musical relation, as a musical envelop which stimulated the handicapped child, in his/her progression, participating more and more with his /her own hands and fingers.

These two “principles” experiments can be considered as the roots of modern music therapy, clinical and pedagogical, in France.

In a first time, the accumulation of experiences - the most of them not without good results - was, and is still true in some places, the paradigm
for research. That is to say: repetition of practices, multiplication of cases, and recording of satisfactions.

And the practice of music therapy generally give a good amount of satisfactions.

The problem appears as a scientific question with the necessity of a justification of the processes in a clinical point of view, either to build a model of understanding of what music therapy is, a relevant theory, or to precise in what cases it really works.

At this point I must say, “satisfaction” - the client’s satisfaction or /and the music therapist’s satisfaction - is not a scientific criterion.

Scientific researches have demonstrated that, on this level, about any sort of psychotherapy is of equivalent value, gives equivalent results. And, on a relational level, we know that “satisfaction” is currently based on illusion, seduction, fusional experience, if not on affective exploitation. Nowadays, ethical questions about sects procedures make us aware of the danger of some of them, even when adepts feel enthusiastic.

Moreover, we all know the power of the placebo effect for many of our remedies, and music therapy is not protected from this effect.

Consequently, the client’s satisfaction is only one argument to comfort music therapy practice and this satisfaction has to be analysed: which relational and technical processes is it the result? This is a central topic for the research in this field.

The psychoanalysis has given the model of the transference process as a tool to understand some of these satisfactions (and unsatisfactions!). And I want to emphasize that music is not an insignificant mediation which could be replaced by any other. The aesthetical dimension of music in
any culture is part of the psychological and pedagogical processes occurring in music therapy. More precisely, it gives a special coloration to the transference we observe in these practices. Satisfaction is a result of a common idealisation between the music therapist and the client (1998, 2001).

I think that the principal part of the resistance of so many music therapists to research in this field is not a lack of tools for research and of training, but, more fundamentally, the avoidance of the narcissistic wound which should be the discovery of the signification of this satisfaction.

I remember that my determination to make researches in this field roots in the expression of satisfaction of a severely depressed woman, who said she recovered after ten sessions of receptive music therapy with me! At that time I was still a student in psychology, but I knew that such a magical recovery was not a good therapeutically result.

_It took a long time to find efficient clues for research and to promote them to the Academic level_

The first experiments made in France were physiological and were developed by dentists (one dentist was co-founder of our association) who used music during the ninety seventieths to soothe down client’s anxiety and to calm pain (Gabai, 1968-69). Finally for this same goals new musics were composed, and even simple sounds used. At the same time, other applications were developed for the preparation of childbirth. In these two developments, the final use of sounds reveals that even with physiological parameters, which are more objective than moods, the
musical experience was too rich to give scientific assurance and clinical security.

The second experiments were behavioral. They try to answer the question: Are the subjective responses to music precisely linked to pieces of music? Is it possible to give a repertoire of the pieces of music the more efficient for music therapy? Is it possible to change the client’s mood or and behavior by using these pieces?

Following the American experiments of the two last world wars in this field (Schoen, Seashore, Murray), we tried to precise this link about some pieces of music chosen for their clinical effectiveness. The results of this experiment were revealing the complexity of such a link, and especially the differences appearing when personality factors were simultaneously tested (1969 in Lecourt 1977).

At the same time, M. Imberty (1980), a French music psychologist worked with the experimental method on the analysis of the semantic linked to very short extracts of pieces of Debussy and Ravel, comparing their structures. The complexity of the results (after years of work) which concerned only some minutes of the musical repertoire, finished to convince me that this was a wrong way of research for music therapy (especially receptive music therapy), at least for me...

It took years to transform my point of view, but the motor of this new research was clear: I needed an understanding which I could not find either in the literature of this field or in my practice.

The turning point was to ask no more the behavioral results of music listening or playing, but to ask the music itself, not a peculiar piece of music supposed to have peculiar power on human behavior, but rather
music considered as a subjective experience, and music as a peculiar common code. Two main questions emerged at that time:

1. When is a sonorous stimulus perceived as music by myself, by the client, by the group of clients? Or, said differently, what is music for a person, for a group, for a culture?
2. What link could be find between the musical structure and the structure of the psyche, link that could support and give sense to the effectiveness of music therapy in some clinical situation?

These new huge questions occupied me for years, but they rapidly opened to experiments giving answers, and this was very motivating.

**QUESTION 1.**

To answer to first question it needs an analysis of the subjective human acoustical experience, from noise, sound, silence, to music, on a developmental point of view (throughout life phases, beginning with the foetus).

The researches made were:

- the study of the literature about these questions
- an experiment made during the seventieths by Dr. Feijoo on the foetus (and many other researches on this point since)
- sonorous experiments in architecture (I work since that time with the Center of Research on Sonorous Space in the School for Architecture of Grenoble).

This was a pleasant occasion to realize that some of our researches were concordant, and some of the new concepts we imagine exchangeable from one field to the other.

- sonorous experiments in music, contemporary music (place of noises, timbers etc.), and especially concrete music, music composed only with natural sounds: Pierre Schaeffer and Pierre Henry with whom I worked during a workshop.
- the clinical ground of the research was a fine observation of the behavior and reactions of profound handicapped patients to noises, sounds and music - mainly non verbal patients -: autistic children, psychotic regressed adults, multihandicapped patients, and Alzheimer patients.
Finally, I proposed, in 1980, in training situations, a clinical group experiment, to explore the relation to sounds of individuals and groups. This procedure uses sonorous free improvisations, their recordings, and verbal expression. The recordings permitted precise analysis and comparison.

Since that time, hundred of groups have been recorded, and in different cultures. Next experience will be in Japan in some weeks.

This procedure proved to be especially relevant for this exploration of the structuring from sound to music, giving like a radiography of the situation of sonorous relationships between people at a moment of the situation, and the evolution through time (repetition of improvisations during the workshop). Quantitative and qualitative results have been published since that time.

The main answer to my question is the moment of the emergency of “music” in a group, the moment the group perceives its production as being “music” (in these experiments the verbalisation about the experience is a good help for the analysis).

In fact I have to concede that this subjective definition of music occurred phenomenologically as a magical experience, a group satisfaction based on a fusional relation. But the creation of the music of the group appeared as a second sort of music: a process beginning in this first fusion and leading to a real composition coming from the inside of the group unconscious process. So “satisfaction” appeared objectively to be linked to the experience of what is music. But the next improvisations show that this mood was a defence against the anxiety aroused by the group situation. A clinical work has to take place behind this first level of satisfaction, the magic of music, throughout the group compositional process and the emergency of a new, differentiated form of musical satisfaction for the members of the group.
QUESTION 2,

This lead us to the second question:

In fact this experimental procedure finally gives support to the two questions, as the group dynamic and the development of a musical structure - beginning with the first noises and sounds explored by the group - appeared simultaneously.

It is why the recordings of the improvisations developed throughout a workshop give a radiography of both.

These results were completed by a research on the “group” structure of music, that is to say the vertical, simultaneous play only possible in this sonorous code, contrarily to verbal expression. To explore this structure I had to make a research on the place of monody and polyphony in different cultures, especially in India, where I went to learn some bases of music and dance, and in the occidental Middle Ages: the passage from monody, from the Gregorian chant, to polyphony, the motetus. This last research consisted of the analysis of the Manuscript of Montpellier (XIVth century), you will find it in one of my books (1994).

The link from the group unconscious processes to the psyche was thus experimentally initiated. The complement came from the psychoanalytical theorisation of group processes. I will not have time to develop that point now and it is also published (1993).

These two researches lead to the signification of the place given to monody or polyphony in a culture at one time: the link from music structure to social groups. Finally, it shows how a model of musical satisfaction is culturally defined.

These relations between the culture, the unconscious processes, the music structure, as they appear in a special improvisational procedure, open to an understanding of music therapeutic processes (defences
included) and to precisians both of its medical and musical usefulness and limits.

**Conclusion:**

This long travel through my personal researches illustrates two important points:

- It generally takes a lot of time to find the “good” question. That is to say a question which opens research and discovery (not repeating formal knowledge).
- Music therapy is a crossroads of many different fields: I needed clinical psychology, music psychology, music personal practice, clinical practice, psychoanalysis, group analysis, musicology and intercultural researches.

This crossroads explains both the richness of music therapy and its complexity.

Finally this demonstration was the key which, in France, opened the academic recognition of this field of research and opened to the development of doctoral researches on this topic either from departments of musicology or psychology.

The collaboration between musicologists, psychologists and music therapists developed since 1985, through academic researches, doctorates, thesis and the organisations of common seminars and colloquium. The next one will take place on the 31st November and the 1st of December of this year on “Music, Freudian, Jungian and Lacanian echoes.

Our Laboratory in the University René Descartes (ex. Sorbonne) presents five of these researches during this European Congress from Anne Marie Duvivier, Gabrielle Fruchard, Adrienne Lerner, Lony Schiltz, and myself in a common research with Pr psychiatry Philippe Dardenne.
The main current topics are:

- the evaluation of the sonorous and musical world of autistic children
- the sonorous and musical world of Alzheimer patients - musical memory.
- the sonorous and musical listening qualities and capacities of school children and adolescents with special difficulties.
- an exploration of families group musics.

We published with Christine Lapoujade, in the Revue de Musicothérapie, the updated repertoire of the French researches in Music Therapy.

“Satisfactions” in music therapy practice are multiple. One of the first client’s satisfaction is often part of a defence against the therapeutic process (even, sometimes the choice of music therapy itself). The idealization associated to music is often also a trap both for the client and the music therapist. Both have to be analysed. The change occurring in a therapeutic process is always a threat for the individual narcissism. But the final satisfaction is not linked to achievements, but rather to the recovery (or discovery) of a free way of feeling, thinking, living (in the limits of the individual potential).

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Therapeutic narrative analysis: 
A methodological proposal for the interpretation of music therapy traces

David Aldridge and Gudrun Aldridge

Abstract
We can begin to understand the process of therapy by looking directly at what happens in the therapy using material from therapeutic sessions. We have used the word “traces” here as a general term referring to the material left behind as an indicator that something has happened. These traces are empirical data. How these events are described and interpreted as therapeutic process is the stuff of methodology. The interpretative process in qualitative research is referred to as hermeneutics. What we have in this paper is a suitable methodology for eliciting understandings and how such understandings are constructed.

In the process of interpretation there are varying stages of abstraction, and we use differing sets of meanings. By combining a constructivist approach with a communications perspective, meanings are chained together to understand the therapeutic process. This is form of narrative analysis applied to the therapeutic process that we call “Therapeutic Narrative Analysis”.

In this paper we intend to present a way of analysing the various traces that we have before us as creative arts therapy researchers, albeit from the perspective of music therapy research. We are using the word trace here to describe either a piece of written material, a transcription or a case report, a musical score, or a taped recording. It could as well be a picture, a series of photographs or videotaped material and may include quantitative material. In laboratory settings these traces would be samples of blood or print-outs from a machine combined with hospital notes and questionnaire scores. These traces must be interpreted, they mean something within a system of meanings.

The difficulty facing most of us in our clinical work is how to analyse the piece of work that we have before us using a systematic procedure that has therapeutic and clinical validity, and that remains true to the art medium itself. If we wish to discover how a particular creative art therapy works, then it is of paramount importance to maintain a focus on the work using the material traces of that work. What we need to develop is a means of discerning at what level we are describing, or interpreting, the traces before us. We will also present

a method for analysing trace texts suitable for music therapy research that is not bound to any particular music therapy orientation and that can be applied to other creative therapy orientations. Thus for music therapy research we may use recordings, transcriptions as musical scores, transcriptions from interviews as texts, and some may indeed use drawings. In this sense, the method proposed in this paper is retrospective although the approach can be used prospectively.

In other contexts we have written of health as narrative performance (Aldridge 2000) and in this paper we present a research method that we now call “Therapeutic Narrative Analysis”. It is intended as a method for the creative arts therapies and has been developed from previous writings about therapy (Aldridge 1985; Aldridge 1988; Aldridge 1990; Aldridge 1992b; Aldridge 1996; Aldridge 1999; Aldridge and Pietroni 1987; Aldridge and Rossiter 1983), and from working with doctoral students during their various methodological quests (Aldridge 1998b; Pilz 1999).

It is a flexible form of research design, and may include quantitative data. At its heart it is hermeneutic; it is based on understanding the meaning of what happens to us in the process of therapy and how we make sense of the world. We refer here to “us”; researchers, therapists and patients. The choice of the term flexible design is used here as the tiresome debate about quantitative / qualitative methods has been superseded with the terms “fixed” and “flexible” much more applicable to clinical practice researching (Robson 2002). In this way we can include quantitative data alongside qualitative material.

I have chosen to use narrative here as this is a broad concept well-suited to research in the creative arts therapies. Central to the narrative methodology presented is the idea of episodes (Aldridge 1999; Harre and Secord 1971). An episode is an event, incident or sequence of events that forms part of a narrative. Taken from the Greek epi = in addition and eisodios = coming in, we have the notion that it is something that is added along the way (eis = in and hodos = way, road or manner). Thus therapeutic narratives are composed of episodes, and it is episodes that we will consider as the basic units for our research methodology. Narrative will be the story that brings these episodes together. In this way we can use a variety of textual materials; written reports, spoken stories, visual media, recorded materials and musical material in the telling of the story. The research part is the analysis of those materials that bring forth new therapeutic understandings; hence, Therapeutic Narrative Analysis.

The process of interpretation

What I want to emphasise in this first section is that we move from the phenomena of the music therapy experience itself through a series of abstractions that are, by their very nature as abstractions, removed from that very initial experience. Such abstraction is inevitable as soon as we try to explain the situation in which we are acting. It is important to know the level at which we are working such that we can begin to understand the various terms and descriptions that are being used. If I were to play you a recording taken from a music therapy session, you would hear in the extract of music that I play an experience that is at one-step removed from the original session. It is tape-recorded and has thereby lost some qualities, although
within the limits of recording fidelity it stays true to the original experience. It is still auditory and in the realm of music. Using the word “music” has already made a statement about the sounds that we have heard. Even attributing the term music to the experience has separated it from random sounds or organised noise. We are in effect making the statement “Construe these sounds you have hear as music”, and we can also add that “This music is in the context of music therapy”. Knowing the context is necessary for defining events.

In the second part of the paper we will demonstrate a method of describing how therapeutic understandings of events can be transcribed as if they were rules of process. This is an attempt to generate expert knowledge from practice. It is important to emphasize that there really are no such “rules”, or a “rule book in the head”. Our intention is to act “as if” there are rules and to see what understandings are gleaned from trying to re-construct our therapeutic actions. Events are inevitably linked together when we describe what we do. “What happened next” is at the centre of the story-teller’s art and is also crucial to the therapeutic plot. Formally expressed in other systems of understanding, it is concerned with therapeutic outcome and an expression of what happened at “follow-up”. It is the basic method that we used in studies of family narratives (Aldridge 1985; Aldridge 1998a) and the development of melody (Aldridge 1998b). In this way or working we are not simply concerned with what happened but also how “it” happened, and the happenings on the way.

When we chain understandings together to make a story or a case history, then we are composing a narrative account. When we begin to try and understand such narrative accounts then we are using a hermeneutic method of therapeutic narrative analysis.

**Therapeutic Narrative Analysis as process.**

As an introduction we offer an overview of phases in the research process. These phases will be elaborated later in the paper:

*Phase 1 Identify the narrative*

Gather the material together that will form the narrative. This may be a case study, or it may be a series of case studies. It is the story that you wish to tell.

*Phase 2 Define the ecology of ideas and settings*

Explicate the theoretical ideas present in the literature or from your own standpoint. This is the initial locating of the research context in the wider perspective of current knowledge (Context 1). While this may appear as a literature review, the intention is not to give an exhaustive account of all possible papers but to locate the study in an ecology of ideas. It may well be that this enfolding of the study into literature contexts will occur throughout the study. Indeed, when we study, we read and collect new material. Similarly, at the end of a study we are challenged to put our new findings into either a new theoretical construct or place it within an established landscape of thought.

Define the setting in which the narrative occurred. This will include details of the place of practice, the demographic details of those involved and may include historical details (Context 2). Contexts 1 and 2 are ecological explanations; the subjects of the researching are placed in an ecology of ideas, times and situations (Aldridge 1985; Aldridge 1992a; Aldridge 1998a; Bateson 1972; Bateson 1978).
Level 3 Interpretation and discourse

When we explain what happens in terms of another system; that is to interpret the musical activity into terms of academic psychology, psychotherapy or systems of medicine.

When we say that the relationship is between the musical activity and the process of healing then we are involved in interpretation.

Level 2 Relevancy and description

When we talk about what happens in the therapeutic situation using the terms of our particular disciplines or therapeutic approach.

Already perceived as music or therapy, therefore demanding a description that is itself based on theory.

Level 1 Experience

The phenomenon as it is experienced.

Sound as it is perceived in the moment.

Figure 1: levels of interpretation

Phase 3 identify the episodes and generate categories.

Identify episodes that are crucial for analysis. This is inevitably a subjective process but this process can be validated by giving the material to colleagues to see if they identify the same episodes. When we collect a wealth of case study material, we cannot often analyse it all. There has to be a discriminatory choice of what we will focus upon.

Generate a set of constructs from that episodic material and identify categories for analysis.

Phase 4 Submit the episodes to analysis.

The episodes are the analysed according to their contents using the guiding framework of the constructs. At this stage it is possible to use a regulative rules based hypothesis.

It is also possible to submit episodes for categorical confirmation to colleagues (see the work from a former doctoral student of mine Pilz 1999) as a way to validate clinical concepts from systematic observations (Eisler, Szmulker, and Dare

Phase 5 Explicate the research narrative.
This is the completed narrative based on the understandings gleaned from the analysis of the episodes. We weave together the categories of understandings from the previous phases and is the process of synthesis following analysis.

Getting at knowledge
One of the tasks of the researcher in a qualitative approach is to make tacit knowledge, as a therapist, available as a propositional knowledge. The purpose of some research is indeed to find out what we know. A conversational paradigm is used here to draw out how researchers understand their own work, and elicit the structure of those understandings that are not immediately apparent in everyday life. From this perspective such work is hermeneutic; that is, it is concerned with the significance of human understandings and their interpretation.

A strength of qualitative research is that it concerns itself with interpretation. It is hermeneutic (Moustakas 1990), and therefore has a resonance with the very processes involved in music therapy as the therapist tries to understand his, or her, patient. It is important to note here that I am working from the premise that therapists invest their practice with an element of deep personal meaning. As the music semiologist Nattiez himself remarks, “The musicologists persona is present behind his or her own discourse” (Nattiez 1990) (p210).

It is also important to emphasise that talking about therapy is always at several steps removed from the actual activity in which we partake. Dancing, painting, singing, acting, doing therapy are different activities to talking about dancing, talking about singing, talking about painting and talking about doing therapy.

We need to emphasise that there are also different levels of interpretation as we see in Figure 1 (see also Aldridge 1996).

Level 1. Experience. Here we have the phenomenon as it is experienced. This is what transpires in the therapy session. It lives and exists in the moment, and is only partially understood. It cannot be wholly reported. We can see, feel, smell, taste and hear what is happening. These are the individual expressive acts themselves as they are performed, painted or posed. We can capture these events onto a medium like videotape or audiotape, although these moments too are “interpreted” through the use of the medium. We can take only a limited perspective from a camera angle, through the orientation of a microphone, and there is always a loss no matter how good the equipment is.

These are the raw data of our experience in practice before we begin to reflect upon them.

Level 2. Revelation and description.
We can talk about what happens in the therapeutic situation in the particular terms of our artistic disciplines. These descriptions are accessible to verification and they emerge into conscious with lexical labels. For example, we can talk about the particular notes and rhythms in music therapy and the particular colours and patterns in art. We play our recorded tapes or show our pictures and describe with words what has happened. This is
the shared element of language that is available for systematic study and is part of our common everyday discourse and is what Nattiez (1990) would regard as the trace or the neutral level of understanding. Whereas level 1 would be “sounds”, this level 2 is already perceived as music, therefore demanding a description, which is itself based on a theory implicit to the listener. When we begin to score the music that we include in our narratives, the very process of scoring is an interpretation, the choice of symbols and time divisions, particularly related to improvisation, is an interpretation and belongs to a cultural context.

Level 3. Interpretation and discourse.
When we come to explain what happens in terms of another system, i.e. to transpose the musical changes into terms of academic psychology, psychotherapy or a system of medicine, or to say what the relationship between the activity is and the process of healing then we are involved in interpretation. For the musicologist Nattiez (1990), this would be the level at which poiesis and esthesis take place; that is, conclusions are drawn about the music. At this level, we make interpretations of what is happening in the therapy; what the activities of therapist and patient mean. In a current climate of evidence-based medicine, we are being challenged to demonstrate that changes occur. However, what many of us have asked in our research over the years is not just what changes occur but what do those changes mean to the sufferer and the practitioner. Consider the dying patient suffering form intractable pain as a consequence of advanced cancer who, when asked by her physician after a music therapy session, reports “I am in Beauty”. This demands interpretation and is significant for the patients, and as it turns out for the well-being of her family and friends. But it would not appear on a questionnaire. The medical outcome was negative, the patient died shortly afterwards. The existential outcome was positive and requires another form of research evidence.

A shared language
At the level of performance, what passes in the therapeutic session exists for itself. However, as therapists working together with patients we do need to talk to each other about what happens and what we do. We also need to talk with our patients about what has happened and understand how they make sense of the therapy. Knowing at which level we are talking will aid our discussion and prevent confusion. My contention is that we can need to find a basic shared language at Level 2, which is based upon descriptions of the artistic process, yet not too far removed from the activity of therapy itself. This is the level where personal construings emerge as revelations, where we put a name to what is going on. It is a level of description. By doing so, we can then discern when the therapeutic process is being described at level 3, i.e. that of interpretation and inference. At this level we begin to find commonalities between individual discourses and these are the languages of the therapeutic discourses that we are trained in. This is a step forward on the road to establishing the meaning of events in clinical practice. There may indeed be further levels of interpretation. Take for example the various schools of psychoanalytic therapy, or the different humanistic approaches; each will have a varying interpretation system that may

<table>
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<th>Constitutive and regulative rules</th>
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<td>Constitutive rules Level 1 the sounds themselves, the experience as itself, the performance as phenomena</td>
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<td>therapeutic interpretation from a fixed point but intuitively used in the therapeutic explanation</td>
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Figure 2: The relationships between Nattiez’s analytic situations, music therapy interpretations and constitutive and regulative rules.
find some commonality at a meta-level of interpretation. This is not confined solely to qualitative research; clinical reports, assessment using standardised questionnaires and reference to statistics are formal systems of interpretation.

Nattiez (1990, pp140-142) gives examples of varying relationships between the description of the music and the interpretations of meaning that those description hold for the researcher. These relationships can be translated into the music therapy situation, and the music therapy research approach. In Figure 2 we see in situations III and V the inclusion of external interpretations of the therapeutic events that will include more than the music itself.

Note that Nattiez, as a musicologist, is willing to include in an analysis more than the musical events themselves. We have a similar situation in music therapy in clinical settings where not only is the music available as a tape recording (situation I) enhanced by a commentary from the therapist (situation II), but there are also clinical reports available from other practitioners (III). What significance those descriptions and interpretations have for practice will then be assumed under situation IV and V, inductive and external esthetics.

Personal construct theory

The personal construct theory of George Kelly (Kelly 1955), and the repertory grid method that is allied to it, were designed specifically to elicit such systems of meaning. This approach does not concern itself with identifying a normative pattern, rather it makes explicit idiosyncratic meanings. However, while each set of meanings is personal, and therefore unique, there is built into the theory awareness that we live in shared cultures and that we can share experiences and meanings with others. The personal construct theory method allows us to make our understandings, our construings, of the world clear to others such that we can identify shared meanings. As Kelly (1955) devised this conversational method for teaching situations, counselling and therapy, we can see the potential relevance for the creative arts therapies and for supervision. Indeed, Kelly discusses human beings as having a scientific approach. He proposes that we develop ideas about the world as hypotheses and then test them out in practice. According to the experiences we have, we then revise our hypotheses in the light of what has happened. Our experiences shape, and are shaped by, our construings. Each situation offers the potential for an alternative construction of reality. The personal construct approach allows us to elicit meanings about specific natural settings as we have experienced, or can imagine, them.

The important factor in this method is that it allows the therapist to stay close to his or her practice and use the appropriate language related to that practice. What it offers is a means of validating subjectivity, we see how the therapist, as researcher, is basing his language in experience. Furthermore, it challenges the researcher to understand that descriptions are not neutral, and to understand the transition from description to interpretation.

Qualitative methods, and particularly, those proposed by Lincoln and Guba (Guba and Lincoln 1989; Lincoln and Guba 1985), present themselves as being constructivist. Therefore, there should be a historical link with Kelly’s personal construct theory. However, nowhere in any of the major books related to qualitative research cited above do we find any
reference to Kelly. It is only in Moustakas (Moustakas 1990) that we find a reference to Kelly in terms of “immersion” where, during the collection of research data, the researcher as “subject” is asked what he or she thinks is being done. While some commentators have found Kelly to be rather cognitive in his approach, this may be due to the way in which he is taught. A reading of Kelly himself stresses the application of beliefs about the world in practice, and that the words that are used to identify constructs are NOT the constructs themselves. He argues that we each of us have a personal belief system by which we actively interpret the world. We create and change the world along with our theories. While we may be charged with bringing those beliefs into the realm of words and conscious expression, it does not mean to say that those beliefs are verbal, or necessarily conscious. This is an important point for the music therapist who is often asked to translate his musical experiences and understandings into the realm of verbal expression. Knowing that some slippage occurs between these realms is an important stage in our understanding.

Making clear constructions of the world is important for establishing credibility. We can see how the world is constructed. The therapist can reflect upon her own construction of the world of clinical practice. Such understandings are discovered when we talk to each other, sometimes called the “conversational paradigm” (Thomas and Harri-Augstein 1985). Each person has their own set of personal meanings that can be communicated, but these meanings can be shared with another person. In this way of working, the personal construing of the world is primary in evaluating the world and leans towards the narrative methods of qualitative research. Sharing those meanings with others must be negotiated and is, therefore, a social activity. To establish our credibility and trustworthiness as researchers, then we need to make explicit our understandings of the world in some form or other. The repertory grid approach is one such way of eliciting and presenting such understandings as a formal process or method.

THE PROCESS

Phase 1 is where the materials to be studied together are gathered together. Narratives have a structure, there are themes and plots that are played out in scenes and vignettes. This is where we gather together the stuff of our story following the definition of our research question. In the tradition of qualitative research, this may be a stage in the process that is re-iterated. We may find as the story unfolds that other scenes need to be included. It is a stage of focussing effort and gathering together the case material to be used. The selection of material may also be influenced by Phase 2.

In Phase 2 we locate our narrative amongst the other stories being told. It is a contextual act where we locate the story in a particular culture of stories. Indeed, we may ask our readers to consider the therapeutic narrative from a particular methodological perspective; as ethnomethodology for example, or as ethnomusicology. Or we may locate that narrative in a theoretical framework like the traditions of psychotherapy and medicine. Others may want to base their stories in concrete data traces drawing from published literature. This phase is where the content of the study is placed into context.
In considering influential theories, these too may influence the choice of case material. This is a process of theoretical sampling NOT random sampling. What is being presented here is a retrospective method.

**Phase 3** brings us to the stage of identifying the categories inherent in what we have collected together. It is a major step of abstraction. From the material that we have before us we need to select episodes that illustrate our focus of interest. This approach is a conceptual method and depends upon the researcher’s ability to identify abstract categories. Abstraction, like interpretation, is a process, often invisible to the researcher, and itself based in a discourse. What we are looking for is recurrent patterns within the material, and then, as Bateson (1978) suggests, the pattern that connects.

We have to identify episodes and then, elicit constructs from those episodes to define the categories for interpretation of the material.

**Selection of episodes as punctuation**

Social scientists have become interested in the way in which we select meaningful patterns of behaviour from the ceaseless stream of events occurring in daily life. This selective structuring has been referred to as *punctuation* (Bateson 1972). To an outside observer, a series of communications can be viewed as an uninterrupted sequence of interchanges but the participants themselves may introduce episodes of interchange which for them has clear beginnings and endings. Punctuation is seen as organizing behavioural events and is vital to interaction. Culturally we share many conventions of punctuation that serve to organize common and important interactional transactions. We observe this when someone says “He started the argument” or “It first began when her work ended”.

The punctuation of events occurs as episodes that we identify. Harre and Secord (Harre and Secord 1971) define an episode as “any part of human life, involving one or more people, in which some internal structure can be determined” (p153). Although imprecise, this definition offers a tool for considering behaviour in that behaviour is located interpersonally and structured (Pearce, Cronen, and Conklin 1979). Episodes can be described in ways that represent the process of construing, and that construing can occur at differing levels of meaning (Aldridge 1999).

The punctuation of events into episodes serves the same function as phrasing in musical time. We organise time to make sense in terms of the performed activity. Thus, if we are looking at videotaped material for examples of interaction with a particular quality, we will identify when that interaction begins and when it ends. We may of course identify differing categories of episode. How we choose to label those episodes is also a matter of construing.

Personally, episodes can be seen as patterns of meanings and behaviours in the minds of individuals. This is a privatised meaning that represents an individuals understanding of the forms of social interaction in which she is participating, or wishes to participate. In a study by Parker (Parker 1981), girls deliberately harming themselves describe what they do as similar to being alone and crying or getting drunk. This construing is quite different to a medical perspective that sees the activity as manipulative or as a cry for help.

Relationally, episodes may be construed
as common patterns of actions that assume a reciprocal perspective (Aldridge and Dallos 1986; Dallos and Aldridge 1987). Such construings are developed through interaction, in the way that people live and play together they co-ordinate an understanding of what experience means. In therapy, when people are used to playing music together, they begin to construe their musical playing mutually. Note that this mutual construing is musical, it is not necessarily verbal. Our challenge is to convert this musical construing of events into a lexical realm if we want to write about it. The basis of the research material will be audiotape or videotape material.

Culturally episodes are patterns of meanings and behaviours that are culturally sanctioned and that exist independently of any particular individual meaning. This is perhaps best seen by the “cry for help” notion of distress. Such construings reflect the concept of significant symbols described by Mead (Mead 1934) that reflect public shared meanings. We would see such cultural construings in the way in which rituals such as marriages and funerals are understood, and ritualized ways of dealing with social events such as greetings, deference and leaving (Geertz 1957). These are seen in music therapy as formalized and ritualized greeting and leaving songs.

**Eliciting constructs**

The first step in this narrative analysis approach is to identify the episodes. The second step is to identify those episodes with names and then to compare those episodes and elicit constructs (see Aldridge 1996).

An advantage of this way of working, as Kelly himself proposed, is that it elicits
verbal labels for constructs that may be pre-verbal. In terms of a researcher's understanding, and bias, the explications from a musico-therapeutic realm of experience into a verbal realm may be of benefit for practice, supervision and research (Aldridge and Aldridge 1996). The verbalization of musical experiences is one step on the way to establishing credibility by getting the practitioner to say what he or she means in his or her own words. However, the strength of this approach is that the basis is the practice and that can be a non-verbal musical trace.

An example from practice

A colleague working with patients is interested in understanding the process of their joint musical playing. He is asked to select episodes as examples that he believes in some way are important in understanding what is happening. He selects thirteen episodes of varying length from his videotapes of sessions and gives those episodes names. The names are not restricted to one word, as you will see they may be a phrase such as "Swing in my brain".

We elicit constructs by considering three of the selected episodes and asking how one episode is different from the other two, and what makes the other two similar. Constructs are assumed to be bipolar; for example "outward-inward" is a construct of response with "outward" at one pole and "inward" at the opposite pole (see Figure 3).

There are two principal forms of data analysis and presentation. One is in the form of a principal components analysis that shows a spatial conceptual structure of the data (see Figure 4). The other is in the form of a focus analysis that shows an hierarchical conceptual structure of the constructs (as we have seen in Figure 3). Each can be displayed graphically. Both displays offer ways of presenting the data for further analysis. The discussion of the presented data is a part of the technique. It is not a finished analysis in terms of unequivocal results. Like all methods of research, the results demand interpretation.

The clinician is then asked if this presentation makes any sense to him and any interpretations are noted. It is important to note here that the construings and their interpretations are always made in the words used by the therapist. An advantage of this method is that a phrase can also be used to represent the pole of a construct; for example, "gives nothing away" (Figure 3).

The supervisor or consultant can then also suggest the patterns that she recognizes within the data that make sense for her too. This negotiating of a common sense is a part of the supervisory activity and the ground for establishing validity in a qualitative paradigm. As we see in Figure 3, it is possible to bundle the constructs together to form categories that are then labelled as "relationship", "responding to the situation" and "balance".

The computational analysis takes the values of the construct as they are assigned to the elements as if they represented points in space. The dimensions of that space are determined by the number of elements involved. The purpose of the analysis is to determine the relationship between the constructs as defined by the elemental space. The

Computation is looking for patterns in the data and organises the constructs and elements until patterns are found. This is termed cluster analysis, in that cluster of similar data are organised together. What we see is how similar the constructs are when they are plotted in space. Two constructs that appear close together may be being used in the same way.

Other constructs may not be equivalent and will effect the whole of the data as a constellation. Indeed, the principal components analysis of the data presents such a stellar appearance (see Figure 4). Here the two principal components of the data are used as axes onto which the constructs are projected. This allows the researcher to gauge the major dimensions

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Figure 4: A principal components analysis of a therapist's construing of episodes with the constructs arranged above and the elements arranged below but using the same axes.
Phase 4 is the stage where the episodes are analysed in terms of the constructs and the overarching categories that have been generated. At this stage it is possible to use a more dynamic understanding based upon constitutive and regulative rules (Aldridge 1985; Aldridge 1992a; Aldridge 1996; Aldridge and Aldridge 1996; Aldridge 1998b).

Meaning and its consequences, the dynamics of understanding

However, while we may find out how the world is constructed by the therapist, we also need to know are the consequences of that meaning. We know the "what" of meaning. We can understand what this means to the therapist. “What happens next” is the appropriate question to ask. Given that we know how a therapists construes a therapeutic event, what does he or she do about is also a vital piece of knowledge. Further more, in the process of therapy, we also need to know what the patient will do next and also interpret what that means. Thus we have a chain of understandings and actions from the perspective of the therapist and the patient. Of course, these interactive understandings are dynamic, they change during the play. In some way, this is at the heart of therapy, while being rule based, what will happen is not fixed, there is always the possibility of something new happening.

Construings and interpretations at different levels can be woven together to formalise a clinical narrative. Such clinical narratives are constructed and based upon rules of interpretation and play.

Rules for the making of sense

Understanding levels of description and interpretation may not be enough in itself. A critic of the construct approach is that...
it is rather static, a vertical understanding of events leading to descriptions and interpretations, yet it does not bring that dynamic horizontal level of linking in time that music has; that is, performance. In trying to make sense of what people do, we can look at how they construct those understandings in a vertical sense, which is seen in levels 1, 2 and 3, based on a constructivist perspective. But, we can also see how sense is actively made by linking those construings in an horizontal form. An everyday example of this is when we question someone about why they have done something (reasons) and then ask them what they did next (action). We seek an understanding, and then we want to know what the consequent action was. A formalised approach can be made in terms of constitutive and regulative

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**Figure 6: A formula for constructing a regulative rule, and examples**

Rules based upon personal construings (Aldridge 1999).

A number of authors suggest that ‘making sense’ is rule based (Harre and Secord 1971; Pearce et al. 1979). These rules can be separated into two forms. One, there are rules of constitution. Two, there are rules of regulation (see Figures 5 and 6). A constitutive rule would be invoked when, in the context of a close relationship,...

---

<table>
<thead>
<tr>
<th>TEXT</th>
<th>CONSTRUCTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A prominent feature of the way in which these patients play music is that they appear to have <strong>no personal connection</strong> with what they are playing.</td>
<td>No personal connection/engaged playing</td>
</tr>
<tr>
<td>They appear to play with a <code>distance</code> from what they are playing. This distance is evident in their <strong>posture</strong>.</td>
<td>Distance from playing/ nearness to the playing</td>
</tr>
<tr>
<td>When they are strong enough to stand their posture is often such that both feet are <strong>not firmly on the ground</strong>, i.e. <strong>their legs are crossed</strong>.</td>
<td>Posture (see below)</td>
</tr>
<tr>
<td>The drumsticks are held loosely in the hands with the <strong>inner wrist uppermost</strong>, and they play from the wrists without involving the whole body.</td>
<td><strong>legs are crossed, as evidence of not firmly on the ground</strong></td>
</tr>
<tr>
<td>This seemingly uncommitted posture make it difficult to play a clear beat on the drum.</td>
<td><strong>inner wrist uppermost, as evidence of</strong></td>
</tr>
<tr>
<td><strong>Any drum beats are loose.</strong></td>
<td>uncommitted posture/committed posture</td>
</tr>
<tr>
<td>Beaters are allowed to fall and rebound rather than being used in a <strong>directed intended beating movement</strong>.</td>
<td>drum beats loose/accurate beating as evidence of</td>
</tr>
<tr>
<td>directed intended beating movement.</td>
<td>directed intended beating movement/haphazard beating</td>
</tr>
</tbody>
</table>

Such texts can then be used to generate constitutive rules (see Figure 8)

**Figure 7: A text of clinical description and related constructs**

<table>
<thead>
<tr>
<th>improvised musical playing in Crohn’s</th>
<th>improvised musical playing in ulcerative colitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>sounds like a gallop</td>
<td>plays with legs crossed</td>
</tr>
<tr>
<td>repetitive playing</td>
<td><strong>postural indicator</strong></td>
</tr>
<tr>
<td>patient cries</td>
<td>unable to initiate</td>
</tr>
<tr>
<td>response to specific harmony</td>
<td>playing</td>
</tr>
<tr>
<td>patient stops playing</td>
<td>response to specific harmony</td>
</tr>
<tr>
<td>melodic playing on glockenspiel</td>
<td>quick and unrestrained</td>
</tr>
<tr>
<td>repetitive playing</td>
<td>avoids coming into</td>
</tr>
<tr>
<td>unco-ordinated playing</td>
<td>contact with the music</td>
</tr>
<tr>
<td>unable to initiate</td>
<td>contact lost</td>
</tr>
<tr>
<td>end</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 8: Constitutive rules generated from a clinical description by one therapist regarding the improvisation of patients with chronic bowel disease**

person enters the room and we say that a particular behaviour (a kiss) counts as evidence of another state (a greeting). Figure 6 shows a formula for constructing
If we changed the context, from one of a close relationship to that of lovers, then the meaning of the same behaviour may change. Instead of being a greeting, it may become an invitation. If we change the context again, and this time make it one of Jesus and his disciples, the kiss becomes an act of betrayal. Context is emphasised as being important for the construction of meaning based on the same behaviour. In this example a kiss constitutes a greeting, an invitation or a betrayal. In our original schema it is an interpretation at level 2 (see Figure 1).

But, as anyone who has been kissed will tell you, it is what happens next that is important.

What happens next is understood and interpreted through regulative rules (see Figure 6). A regulative rule would be invoked when we say if this behaviour (a kiss) counts as evidence of a particular state (maintaining friendship) then do a particular activity (kiss in return).

In Figures 7 and 8 we see how rules of regulation can be linked to piece together behaviour in a music therapy session. In the upper half of the diagram we see a sample of text taken from a case description. Key words are highlighted and noted as relevant constructs. We can read that personal connection is important, and that there are certain behavioural indicators such as posture and the positioning of the limbs that can be interpreted as indicators for the music therapy.

In the lower half of Figure 8 these constructs have been assembled into regulative rules using the clinicians report. We see how textual data can be assembled according to a hierarchy of understandings to demonstrate at what level the musical behaviour is being
described, and how those descriptions are further interpreted. Thus we have an indicator of the complexity of the music therapy discourse that is taking place. This allows music therapists to explicate both what is taking place and their understandings related to what is taking place. There could of course be other interpretations of the same behaviour, and these could be useful to engage in a comparative discourse.

Such an approach gives a way of formally charting what meanings are associated with therapeutic activity and change. Meanings cannot be counted or measured, but they can be expressed and analysed. In Figure 9 we see that interpreting a loss of precision in the rhythmic playing of patients suffering with Alzheimer’s disease, then this counts as a loss of concentration and intent that is interpreted as a sign of progressive deterioration. In the context of melodic playing, when melodic tension arises, this counts as an example of dynamic power and is interpreted as an experience of form.

The benefit of this approach is that we see the chain or reasoning between events as they are described and the interpretations that are made.

We can then combine our understandings of levels of interpretation (in Figures 1 and 2) with those of constitution and apply them to understanding musical texts. In Figure 10 we see how a musical motif counts as loss of precision and this in interpreted as assign of progressive deterioration. The benefit of this approach is that we can base our interpretation on a musical trace, originally the recorded sounds, and make that bridge to a lexical description showing how we arrived at the interpretation as it occurs in a specific context. We emphasis context here as the intention is not to make a generalised interpretation, yet, but to make a specific localised statement.

Validation of categories

Once particular categories are recognised then it is possible to submit these examples to other therapists or researchers for validation. For example, Wolfgang Pilz (Pilz 1999) focussed on the concept of “resistance in music therapy” in his doctoral dissertation. He asked various panels of listeners to hear audiotape examples of what he described as resistance distributed amongst an equal number of audio examples where there seemed to be “no resistance”. Other experienced therapists were able to recognise this clinical phenomenon, and more importantly, novice listeners could also be taught to recognise the phenomenon.

Peter Hoffmann (2002), has identified those moments in music therapy when phrasing occurs. He has submitted examples of phrased and un-phrased playing to a panel of colleagues, and they were able to identify the phenomena accurately. Thus we are able to validate our subjective understandings made at an abstract level by submitting examples for validation to the broader community of practitioners or inquirers. This is the point that Glaser makes, subjective understanding when abstracted from empirical data become objective. I have expressed this elsewhere as the relationship between personal construing and cultural construings; although we are individuals our understandings are also related to the cultures in which we actively participate (this also means non-verbally).

Phase Five is the stage where the understandings are then woven together to form the narrative again based upon the categories discovered during the

Figure 11: A therapeutic narrative analysis showing the development of a melody based upon the categories of constructs and the categories of episodes.

analysis. We see this in Gudrun Aldridge’s (1998) work where she takes categories generated from constructs and categories generated from episodes to describe the development of a melody. Here the narrative structure is involved initially with episodes of communicating, integrating, leading and forming. It is the concept of integrating that then leads into the phase of independent playing that precedes the final completed melody (see Figure 11).

**Conclusion**

We can begin to understand the process of therapy by looking directly at what happens in the therapy using material from therapeutic sessions. We have used the word “traces” here as a general term referring to the material left behind as an indicator that something has happened. These traces are empirical data. How these events are described and interpreted as therapeutic process is the stuff of methodology. The interpretative process in qualitative research is referred to a hermeneutics. What we have in this paper is a suitable methodology for eliciting understandings and how such understandings are constructed.

In the process of interpretation there are varying stages of abstraction, and we use differing sets of meanings. By using a constructivist approach we can elicit meanings from events and see how events are understood as a system of meanings. Furthermore, by combining a constructivist approach with a communications perspective, we see how meanings are chained together to understand the therapeutic process. This is form of narrative analysis applied to the therapeutic process that we call “Therapeutic narrative analysis”.

Communication is dependent upon linking behaviours together. How those links are made, and what they constitute is basis of this form of research analysis. Narrative
structures are the abstract form of case histories, clinical reports and what our patients tell us about their lives. Events gain meaning in the way in which they are linked together. Therapeutic narrative analysis elicits those links between events, the hermeneutic lies in the linking are much as in the events. Meaning has to be made, it is an activity. The same can be said of science, it is not static but is a dynamic process of understanding.

Central to the understandings is the concept of context. Culture itself is a context, and within a cultural context events will gain different meanings. These nested forms of understandings within specific are given a formality here in terms of constitutive and regulative rules. By explicating how we describe what happens from the traces of therapy, we begin to make the processes of therapy accessible to others and lend credibility to our accounts.

Language is a joint event by which we understand the coherence of what happens in our lives. The maintenance of meaning in everyday life is a social act. What we are asked to do is to elicit the hidden rules by which meaning is being constantly constituted and regulated. To this end, we can share our own meanings of the world with our colleagues and promote a community of inquiry.


Aldridge, D and Dallos, R (1986) Distinguishing families where suicidal behavior is present from families where suicidal behavior is absent. Journal of Family Therapy 8, 243-252.


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**Phase 1 Identify the narrative**

Gather the material together that will form the narrative. This may be a case study, or it may be a series of case studies. It is the story that you wish to tell.

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**Phase 2 Define the ecology of ideas and settings**

Explicate the theoretical ideas present in the literature or from your own standpoint. This is the initial locating of the research context in the wider perspective of current knowledge (Context 1).

Define the setting in which the narrative occurred. This will include details of the place of practice, the demographic details of those involved and may include historical details (Context 2).

---

**Phase 3 Identify the episodes and generate categories.**

Identify episodes that are crucial for analysis.

Generate a set of constructs from that episodic material and identify categories for analysis.

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**Phase 4 Submit the episodes to analysis**

The episodes are the analysed according to their contents using the guiding framework of the constructs. At this stage it is possible to use a regulative rules based hypothesis.

It is also possible to submit episodes for categorical confirmation to colleagues.

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**Phase 5 Explicate the research narrative.**

Interpretations based on therapeutic traces are synthesised to form a therapeutic narrative.

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Phases of Therapeutic Narrative Analysis overview

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Was am Gongklang bewirkt welche Erfahrung beim Hörer?
Musikpsychologische Details aus einer qualitativen Studie

Christoph Wagner, Anna Körting, Henrik Jungaberle

Abstract

In this partial evaluation, the authors explore the relation between actual musical events in experiencing the gong, and comments made by 22 participants on their personal perception of that experience. The selective assessment presented here is part of a wider music-psychology study into how we experience monochrome and minimalistic music ("Gong, Monochord, ein Mix aus beiden und 18 Musicians, Steve Reich" (Jungaberle 2002). The objective of this partial evaluation was to provide material for further research with the specific purpose of designing a questionnaire on the perception of monochrome music and to give advice on a more systematic use of the gong in therapy. The focus of the evaluation was on a subjectively perceived and reported connection between musical perceptions and personal experience. It is remarkable that specific musical qualities are addressed rarely, despite specific inquiries. The perception of upper and lower registers, often simultaneous and often in the form of figure-background processes, therefore seems to be the most characteristic aspect in listening to a gong. The low notes of the gong receive particular attention, which is probably connected with an unusually intensified
spatial processing of sounds. Low gong notes are mainly experienced as pleasant, frequently as immediately physical. Perception of vibrations, transferred by the ground or in the inner body, occur frequently and usually are reported as something agreeable. Deep gong notes often induce a feeling of being carried. Gradually increasing volume is often experienced as analogous with swelling emotions that may be either fearful or joyful. Gong effects are unspecific in this context. Playing the gong often means that the threshold of pain is reached in auditory perception; some experience this as a breakthrough, others as unpleasant and painful. Surprisingly, positive emotions dominate in this selection of reported emotions, too; most often, listeners report feelings of being sheltered in the form of “being carried”; a result of the stereophonic effect.

Einleitung - Was ist das musikalische am Gongerleben?


systematischere Anwendung des Gongs im therapeutischen Rahmen zu geben.

Design der Studie: Musikerleben im Spiegel offener Selbstberichte


Anschließend wurden die Teilnehmer aufgefordert, sich eine bequeme Position auf zur Verfügung stehenden Matten zu suchen. 21 Teilnehmer wählten eine liegende, eine Teilnehmerin eine sitzende Haltung. In einer kurzen wahrnehmungszentrierten Entspannungsanleitung sollte danach die Aufmerksamkeit in Form einer Körperreise auf das eigene Erleben gelenkt werden.

Das vierzigminütige Gongspiel folgte einem groben Schema: Spannung und Dynamik sollten bis zur Mitte der Sitzung leicht ansteigen. Dies
wurde durch eine Erhöhung der Lautstärke und ein schnelleres Pulsieren des Anschlages erreicht. Danach wurden Dynamik und Tempo des Spiels wieder kontinuierlich reduziert. Der Gong verklang schließlich im Raum. Es wurde bewusst ein naturalistisches Setting gewählt und eine experimentgleiche Identität der Sitzungen gar nicht erst angestrebt. Gespielt wurden nacheinander ein in Europa gebauter Kupfergong, ein javanesischer Buckelgong sowie ein großes chinesisches Tamtam (vgl. Figure 1 on page 5). Diese drei Instrumente bieten eine breite Variation an Gongklängen. Umrahmt wurde das Gongspiel von jeweils dreimaligem Anschlagen der Klangschale - diese sollten Beginn und Ende der Sitzung markieren.

**FIGURE 1.** Kupfer-Gong, Buckelgong und Tamtam

Direkt nach dem Hörerlebnis wurde ein ebenfalls selbstentwickelter Fragebogen zur Beschreibung des Musikerlebens (FBM Version 1.2) mit Fragen zum Entspannungs- bzw. Anspannungs niveau, Klangerlebnisqualitäten wie angenehm vs. unangenehm, nah vs. fern, dem Vorhandensein bestimmter Erlebnisformen wie Innerer Bilder, Geruchsempfindungen etc. sowie einer Liste mit Thrills (Kribbeln, Gänsehaut, flaues Gefühl im Magen etc.) gegeben. Im Mittelpunkt des Erhebungsin-
Instruments standen jedoch vier offene zu beantwortende Fragen, deren kategorisierende Auswertung wir hier vorstellen:

(1) Bitte beschreiben Sie in freien Worten, welche Erlebnisse Sie während des Musikhörens hatten.

(2) Hatte ihre Hörrfahrung bestimmte Phasen oder Abschnitte? Wenn ja, welche?

(3) Versuchen Sie einmal ihre eigenen Erfahrungen mit dieser Musik zu unterscheiden von der Musik selbst. - Beschreiben Sie bitte in freien Worten diese Musik (bzw. die Klänge oder Geräusche), die Sie eben gehört haben.

(4) Bringen Sie Ihre Reaktionen auf die Musik, oder eine bestimmte dieser Reaktionen, mit einer spezifischen Veränderung in der Musik in Verbindung (z.B. Lautstärkeveränderung, Tempowechsel etc.)? Der Gegenstand dieses Berichtes wurde den Probanden also zur subjektiven Beantwortung vorgelegt. Sie benötigten zwischen fünf und zwanzig Minuten zur Beantwortung der Fragen.

Nachdem alle Teilnehmer den Fragebogen ausgefüllt hatten, luden wir sie zu einem Dialog in der Gruppe ein. Dies sollte auch dazu dienen, auf etwaige negative emotionale Reaktionen eingehen zu können.

STICHPROBENBESCHREIBUNG: WER MACHTET MIT?

Abitur, eine mittlere Reife, und zwei den Hauptschulabschluss. Unsere Versuchspersonen hatten also insgesamt ein recht hohes Bildungsniveau.


**Ergebnisse**

Was am Gongklang ist verantwortlich dafür, dass Studienteilnehmer X eine ganz bestimmte Erfahrung macht? Und wie sieht diese Erfahrung aus? Als Ergebnis dieser zwei Fragestellungen formulierten wir unsere Codes, die immer einen musikalischen Wirkfaktor und einen damit verbundenen Erlebensmodus enthalten. Die Codes lassen sich in folgende fünf Familien (= Gruppen von Codes) gliedern.

**Familie 1**
- Frequenz (17 Codes, 24 Zitate)
  Die Zuhörer differenzierten in hohe und tiefe Frequenzen

**Familie 2**
- Lautstärkeveränderung (10 Codes, 19 Zitate)
  Zunehmende oder abnehmende Lautstärke, bzw. gleichbleibend leise oder laute Dynamik beim Gongspiel wurden als Auslöser der jeweiligen Erfahrung deklariert

**Familie 3**
- Eigenheiten spezifischer Gongs (Kupfer-, Javagong, Tamtam) (21 Codes, 28 Zitate)
  Es gab unterschiedliche Reaktionen auf einzelne Gongs

**Familie 4**
- Tempo (2 Codes, 3 Zitate)

**Familie 5**
- Parameterunspezifische Erfahrung (18 Codes, 70 Zitate)
  In dieser Familie codierten wir alle Erfahrungsberichte, in denen trotz spezifischer Fragestellung (siehe Frage 4 in Abschnitt 2.1.) keine oder für uns nicht nachvollziehbare Angaben zur Ursache der jeweils geschilderten Erfahrung gemacht wurden - die freilich als irgendwie musikalisch erkennbar war.

Es wird deutlich, dass viele dieser Codes sehr schwach durch Zitate belegt waren, weshalb wir bei dieser Teilfrage der Studie an vielen Stellen nur illustrierend sein können.

Bei den insgesamt 67 vergebenen Codes bei 138 Textstellen ließen sich familienübergreifend aber auch Gemeinsamkeiten bezüglich der Erlebensmodi finden: So wird bei 25 Codes emotionales Erleben geschildert. In weiteren 20 Codes berichten die Teilnehmer von körperlichen Reaktionen, die sie in direkten Zusammenhang mit dem Gongklang bringen.

**Spezifische Darstellung der Ergebnisse: Welche Erfahrungen wurden mit welchen musikalischen Ursachen verbunden?**


Eine leichte Tendenz zu einer typischen Erlebnisweise der tiefen Töne ist im Gefühl der Geborgenheit (7 Zitate) zu erkennen: “...die tiefen Töne haben ein Gefühl von Fürsorge, Getragensein ausgelöst...”, “Später ver-tieftes Hineinfallen, mitgehen, mit den Klangwellen, besonders bei den dunklen Tönen, nach Vertiefung, auch mitgehen...”.

Was am Gongklang bewirkt welche Erfahrung beim Hörer? Musikpsychologische Details aus einer qualitativen Studie


Die einzelnen physischen Reaktionen sind jedoch sehr individuell und sie beziehen sich nur vereinzelt auf bestimmte Körperteile.

Wir codierten insgesamt 16 Zitate, in denen Dynamik als Erfahrungssursache genannt wurde.

V.a. bei zunehmender bzw. großer Lautstärke lenkten die Teilnehmern ihre Aufmerksamkeit auf diesen Parameter (13 von 16 Zitaten), der stets mit einer Intensivierung des körperlichen und/oder emotionalen Erlebens verknüpft war.

Eine Teilnehmerin schrieb beispielsweise: „Lautstärkenänderung brachte ein mehr oder weniger starkes Pulsieren der Töne durch den Körper mit sich“. Eine andere bemerkte: „Lautstärke brachte mehr Intensität des Fühlens, des Reagierens auf die Musik“.

Insgesamt waren die Erfahrungen bei ansteigender bzw. hoher Lautstärke dennoch individuell. Eine leichte Tendenz kann man lediglich darin sehen, dass sechs Zuhörerinnen das Erlebte als unangenehm konnotierten. So beispielsweise in den äußerungen „laute Klänge/Geräusche eher ablehnend“ oder „Lautstärke weckte Aufmerksamkeit, wurde aber auch aufdringlich“. Dem stehen aber auch Teilnehmer gegenüber, die eine
Erhöhung der Intensität durch größere Lautstärke geradezu herbeigehalten. In den drei Erfahrungsberichten, die sich auf abnehmende oder leise Dynamik bezogen (3:16) konnten wir dagegen keine Spur von negativem Erleben finden.

Es ist also zu vermuten, dass anwachsende Laustärke meist in Zusammenhang mit der Angst vor überwältigenden inneren Erlebnissen gesehen wird. Die Höfer können vorübergehend nicht einschätzen, 'wie weit das noch gehen' mag und ob 'das auszuhalten ist'. Vor diesem Hintergrund wäre das Erleben dann unter Rückgriff auf die perinatalen Matrizen von Grof (Grof 1998) zu diskutieren. Bei einigen Teilnehmern steht deutlich die Befürchtung vor emotionaler Überflutung im Hintergrund ihrer Äußerungen.


In den Schilderungen unserer Probanden beziehen sich nur drei Zitate auf eine direkte Tempowahrnehmung (obwohl dies als Beispiel in der Klammer von Frage 4 angegeben wurde). Dabei empfinden zwei Teilnehmer ein wechselhaftes Tempo als unruhestiftend: "...Tempowechsel verursachte Unruhe", "bei schnellerem Tempowechsel empfand ich unruhige Gefühle."

Das Klanggeschehen beim Gong ist in der Regel deutlich durch andere musikalische Faktoren dominiert.
DIE VERBINDUNG SPEZIFISCHER GONGS UND BESTIMMTER ERFahrung:


In acht der elf Zitate reagierten die Probanden in unseren Sitzungen mit negativen Gefühlen auf den Buckelgong: “Der ganz tiefe Gong war mir äußerst unangenehm. Meine Ohren schmerzten ich bekam Angst, wollte nicht mehr zuhören, wurde aggressiv. War froh, wie das vorbei war”. “Java Gong: etwas bedrohlich, über einen rüberschwappend”.

Neben den negativen Gefühlen, wird jedoch von anderen interessanten, individuellen Wahrnehmungen berichtet: “Mittlerer tiefer Gong: fährt mir in den Leib weckt tiefe Gefühl, sehne mich körperlich nach einem Partner”. “Gong: tief, tragend”.

Kupfer-Gong (mit einem verhältnismässig harten Schlegel gespielt).

Ganz gegensätzlich wurde der kleinere Kupfer-Gong erlebt. In fünf von sieben Zitaten wurden positive Gefühle wahrgenommen: ”Die tieferen Töne (...) waren äußerst angenehm, mein Puls schien sich anzupassen, Wellen liefen durch den gesamten Körper”. “Nur, dass ich diesen rhyth-
misch immer wiederkehrenden Gongklang sehr wohlig wahrnahm und bettend."

**Tamtam (mit zwei weichen Schlegeln gespielt).** Die musikalisch-akustische Eigentümlichkeit dieses Gongs sind gewiss die deutlich hörbaren Frequenzüberlappungen und Oberton(reihe) sowie eine ständig pulsierende Veränderung des Gesamtklangeindruckes. Von den drei gespielten Gongs ist es derjenige, der sich am wenigsten "kontrolliert" spielt lässt, d.h. ein erhebliches "Eigenleben" entwickelt.


Auffällig sind die Assoziationen zu Flugzeugmotorgeräuschen, die auch außerhalb dieser Berichte regelmäßig erwähnt werden. Generationensbedingt erinnern sich Menschen, welche beispielsweise die Bombardements auf Dresden miterlebt haben, an genau diese Ereignisse.

Viele der musikbezogenen Äußerungen unserer Probanden ließen sich jedoch nicht den herkömmlichen musikalischen Parametern zuordnen, sei es weil diese vergessen es schriftlich niederzulegen oder wahrscheinlicher keine Differenzierung in Einzelaspekte vorgenommen haben. Diese
parameterunspezifische Schilderungen bieten die Gelegenheit einen kleinen Einblick in allgemeinere Erlebnisweisen des Gongklanges zu leisten.


Weiterhin gab es vier sehr unterschiedliche körperliche Erfahrungen, die später familienübergreifend noch genauer betrachtet werden, und fünf schwer einzuordnende Einzelschilderungen wie z.B. “Damit Emotionen auftauchen brauche ich offensichtlich eine Melodie oder einen Rhythmus, Musik jedenfalls, nicht nur Töne allein. Das ist mir erst hier klar geworden (hier werden ja nur Töne produziert)”.


Diesen positiven Emotionen stehen 14 Zitate mit einem breiten Spektrum emotional negativer Erfahrungsberichte gegenüber. Das von eher undifferenzierten Schilderungen unangenehmer Emotionen “Es gab im Verlauf jedoch auch etwas breig, diffuse Klänge, die unangenehm waren, etwa wie der Krach am Flughafen” bis zu Berichten über Aggression und Schmerz reichte, die für die Teilnehmerin sehr intensiv gewesen zu sein schienen. “Meine Ohren schmerzten, ich bekam Angst, wollte nicht mehr zuhören, wurde aggressiv. War froh, wie das vorbei war.”


Unser Versuch einer Zuordnung dieser physischen Reaktionen zu spezifischen musikalischen Parametern war allerdings erfolglos: Die Codes konnten nur durch wenige Zitate gesichert werden, was bedeutet, dass die Erfahrungen sehr individuell waren. Alle Versuche Gongklänge bestimmten Körperreaktionen oder -regionen zuzuordnen sind durch diese Studie nicht zu bestätigen.


In dieser Teilauswertung haben wir nun jedoch versucht, die Zitate, die sich auf physische Reaktionen beziehen zu ordnen. Wir konnten so verschiedene Regionen und Arten leiblicher Empfindung unterscheiden.

"Mir wird heiß" - Temperaturwahrnehmung

**FIGURE 3. Einfluss der Gongklänge auf bestimmte Körperregionen**

Becken, Nase, Ohren, Arme - Einzelne Körperstellen

meiner Nase gespürt und eingeatmet, aber dann wurde es zu viel und es wurde schwieriger zu atmen, (…). Ich habe den Klang vom Gong in meinem linken Arm gespürt, in meiner linken Hand, ich habe gespürt den Puls meiner Venen. Dann konnte das Blut nicht mehr so frei fließen, (…). Dann Ohrenschmerzen in meinem rechten Ohr, dann mein Kiefer wurde angespannt. Mein Mund hatte einen trockenen sauren Geschmack.“

“Der tiefe Gong war eindringlicher im Becken (Po, Beine), wenn ich auf dem Bauch lag.” Beim letzten Zitat wurde eine deutliche Verbindung zwischen tiefen Frequenzen und der Reaktion im Becken erwähnt.

Ganzer Körper


Schmerzen

**Gong** (Tamtam, d.A.) hat mir einmal sogar das rechte Handgelenk geschmerzt beim Klang, auch fast das Zahnfleisch.”

**Körperliche Aktivierung**


**Taktil**


den dunklen Gongs. Dieses auch in die weite Tiefe tragen lassen.” Alle Zitate lassen keine parameterspezifischen Verbindungen erkennen. Es scheint also auf die Wahrnehmungseinstellung und den anfänglichen Grad der Entspannung anzukommen.

Einschlafen


**Diskussion und Schlussfolgerungen**


Die definierteren, tiefen Klänge des Java-Gongs werden oft als mächtig und überwältigend beschrieben. Die physische Gestalt steht hier in Analogie zur Klangwirkung. Der kleinere Kupfergong wurde nie als angst- oder flößend geschildert. Das Tamtam wurde oft als imaginationsfördernd geschildert und bewirkt unserer weiteren Erfahrung nach nicht selten Assoziationen an Flugmotorengeräusche - negativ wirkt sich dies vor allem auf das Erleben von Menschen aus, die lebensgeschichtlich damit Kampfflieger und Bombardierung verknüpfen müssen. Bei den einzelnen Gongs wurden uns also individuelle Eigenschaften hinsichtlich des
Reaktionsspektrums deutlich, deren genaue Erforschung zu einer effektiveren Anwendung beitragen könnte.


Ferner zeichnet sich ab, dass die Reaktionen auf unterschiedliche Gongs doch erstaunlich differenziert ausfallen. Hierbei überraschte uns
besonders, dass die meisten Imaginationsschilderungen im Zusammenhang mit dem Tamtam genannt wurden.

FRAGESTELLUNGEN ZUKÜNFTIGER STUDIEN


2. Der sehr oft auftretende Begriff der "Schwingungen" sollte untersucht werden: Damit meinen die Teilnehmer solcher Gongsitzungen eine Erfahrung, die physische und/oder psychische Wahrnehmungen umfasst. Er wird meist zur Kennzeichnung positiver Erfahrungen benutzt.


sowohl über Selbstauskünfte in Form von Fragebögen, also auch über Magnetresonanz- oder EEG-Verfahren versucht werden.


7. Ein Fragebogeninstrument sollte die Phasenhaftigkeit der Gongerfahrung thematisieren, den individuellen Umgang mit intensiver werdenden Emotionen und Körpererfahrungen, Durchbrucherlebnisse und -erwartungen, transpersonale Erfahrungen, negative Klangassoziationen (z.B. die erwähnten Flugzeugmotoren), Körperhaltungen beim Hören und veränderte Wachbewusstseinszustände.

Literatur


Welcome to the latest issue of music therapy today

A recent conference in Berkeley, California discussed whether our preferences in music and art are learned or innate. "Many experts believe that our artistic choices are entirely dependent on cultural influences. But proponents of neuroaesthetics think that there are pointers to taste, and that studying the brain will help to find them." We’ll see. To get some more information on this, click on the following link http://brain.berkeley.edu/~plaisir/conf.htm or take a look at our newsletter.

This issue is filled up with work and thoughts on themes which are not directly centered on music therapy; but the more you look at embodiment and think about spirituality, breathing and interaction, therapy settings, architecture and environment, the more you might feel how unconsciously forming patterns are inherent terms of influence in our daily music therapy work. We live and work in an ecology that also has an aesthetic. Therapy happens at a certain place in time and we are connected to what surrounds us. Sure, for some it would be even a big advance to have a therapy room to work, not to share it with other therapists of the hospital or school or wherever you work. This is another issue to discuss. But as therapists working with an artistic medium we might be more sensitive to the above-mentioned aspects. Let’s read what our authors think about this.
Our first article **Music Therapy Training Aotearoa – Embracing and Accessing a World of Perspectives** comes from **Robert Krout**. He is head of the Music Therapy Programme at Massey University in New Zealand. He describes the Massey University Master of Music Therapy programme and how international perspectives in music therapy will be reflected, accessed, and included in that programme via technology and the World Wide Web. The concept of perspective is briefly discussed and used to tie together various themes throughout the article.

In our last issue we published an article from **Lucanne Magill**. It was her response to Reverend Michael Maine and his talk at the World Conference for Music Therapy in Oxford, Uk. It centered on Music Therapy and spirituality. To continue this trace of ideas our next research paper comes from **David Aldridge: Music therapy and spirituality; A transcendental understanding of suffering** This paper offers some definitions of spirituality and religion as sometimes the two terms are confounded. His position is that if spirituality is about the individual, ineffable and implicit; religion is about the social, spoken and explicit. Such definitions are an attempt to explicate the practices whereby spirituality is achieved. Spirituality lends meaning and purpose to our lives, these purposes help us transcend what we are.

The ability to rise above suffering, to go beyond the present situation to a realm where life takes on another, perhaps deeper, significance is an important factor in palliative care. Music therapy facilitates the process of connecting to that which is spiritually significant for the patient, thereby transforming experiences of suffering into those of meaning. This has been traditionally termed transcendence – to rise
above the immediate situation, and is the basis of hope.

Another research paper from David Aldridge focuses on Breath in Healing. Many healing traditions have used breath as vehicle for healing. Two specific healing initiatives are used as illustrations of how breath is both a subtle organizing property and a material manifestation. Singing, in the context of music therapy, organizes intentionally the physiological abilities of another person as they recover from coma. The second healing initiative is that of Qigong Yangsheng for the treatment of asthma. Breathing is a central principle in communication and healing and forms the basis of many therapeutic disciplines. Perhaps we can encourage our clinician colleagues toward be aware of their breathing and be less aware of their machines.

We started to share some music therapy recordings in our last issue as ‘Music Showcase’. The following therapy recording Folsom Prison from Johnny Cash features Jerome on Voice, a twenty years old rock n’ roll musician who was diagnosed with blood cancer. Alessandro Ricciarelli, music therapist at Memorial Sloan-Kettering Cancer Center, New York City, plays guitar. This was one of the songs that has been Jeromes’ therapeia, his voice and companion through his last days of life...

Gathering together is important for us all as therapists, researchers and teachers. The current state of plannings and environment of the forthcoming 6th European
Conference on Music therapy in Jyväskylä, Finland 2004. You will read about the different topics and themes, which will be discussed, about the beautiful buildings from Alvar Aalto, which will host us during our time of stay there. David Aldridge has written some impressions on architecture and philosophy of the building, it’s sights and aesthetics and points on parallels to processes music therapy.

In this direction points our next practice article from Karen Thoms. She has written in one of our former issues on Music Therapy and Cochlear Implants. With her new article “You live to express yourself, and in doing so, you enhance the world“ she presents her workplace and it’s new environmental architecture, which has been designed to be suitable to the inhabitants’ needs. She describes this process of rebuilding and all the discomfort for the inhabitants. “I have been part of this reorganisation with my music therapy sessions and have been trying to give the inhabitants room to discover and develop their communicative and practical artistic abilities in music therapy.”

The last research article “Eine Zusammenstellung von Studien/Veröffentlichungen über Künstlerische Therapien in der Akutmedizin und Onkologie” is a compilation of studies about art therapy in medicine and oncology. It includes a number of finished and ongoing studies. This article is written in German. But by scanning the article it is possible for those
interested in such work to find some hints of what is going on. This document is part of an ongoing discussion on the use and research on art therapy issues in hospitals. This compilation is done by David Aldridge, Harald Gruber, Bettina Kunzmann and Joachim Weis.

Until we read again
Joerg Fachner
"You live to express yourself, and in doing so, you enhance the world" (Henry Miller)

Karen Thoms

Abstract

For several months now, the inhabitants and staff members of Leben­sarche Königsborn have been suffering from construction noises – walls are torn out, floors taken up, new parquet floors laid ... All this noise is
due to the conversion and new arrangement of the living and therapy quarters at Lebensarche Königsborn; at the same time, it is the symbolic expression of a reorganisation in structures and concepts pursued at this institution. For almost two years I have been part of this reorganisation with my music therapy sessions and have been trying to give the inhabitants room to discover and develop their communicative and practical artistic abilities in music therapy.

The Institution

The institution Lebensarche Königsborn is located in Unna-Königsborn in the Eastern part of the Ruhr district and gradually, step by step, has become what it is today: a centre for children, adolescents and young adults with neurological impairments.

The history of the Lebenszentrum (or “centre of life”) Königsborn started in 1882 with the foundation of a health resort for working class children. For some time it served as a tuberculosis sanatorium and later became a hospital specialized in child neurology and social pediatrics. After a variety of expansions and additions, e.g. a kindergarten (1971), hospital school (1978), centre for social pediatrics (1994) and Haus Königsborn (1997), the focus of work at the centre today is the care and treatment of children, adolescents and young adults with serious multiple disabilities and neurological damage.

The last part of the centre to be opened was Lebensarche (“ark of life” as in Noah’s Ark) in 2000. A unit of 50 beds at the neurology clinic is being restructured to form a residential facility. This form of care is adapted to the needs of children and adolescents: their impairments in daily life are
so considerable that they require continuous treatment and nursing (see info box I). For a variety of reasons, this type of care is not feasible at home; this is why children and adolescents from all over NRW live at the Lebenszentrum Königsborn for many years.

**FIGURE 2. A new residential facility is ready**

Such a reorganisation involves changes as to premises, nursing staff and concepts. Step by step, long hospital wards are converted to resident units. The team of therapists is expanded and new therapy fields like music therapy and arts therapy are added. (From 1997, music therapy has been part of the treatment plan in Königsborn.)

Subsequent to the conversion as scheduled, 7 resident groups will comprise 7 to 8 inhabitants each, with family-like structures and the support of an interdisciplinary team of care-givers. 15 therapists working in physio, ergo, music and arts therapies and also logopedics are involved in projects geared to the needs of the inhabitants. Children and adolescents
of school age also attend the school at Königsborn, which is a special school for disabled children with official state recognition.

The objectives pursued here have been developed in close cooperation with Prof. Dr. A. Fröhlich and are based on the principle of normalisation (see info box II) defined by Nirje: patients with serious disabilities cannot be equated with other patients; their serious disability is their individual normality.

The general objective of the interdisciplinary team is to enable the inhabitants to enjoy as much normalcy as possible in leading their lives and pursuing their school education or training, with a maximum of independence, self-determination and social integration.

Music therapy at the Lebensarche

Due to the current rebuilding activities, therapists frequently have to accept compromises as to rooms for sessions – the music therapy room, however, is far better than just a compromise solution. In the centre of the room there is a black piano, with a woolen blanket on the lid so that children and adolescents may be positioned on top of the piano. Drums, rattles, castanets and a triangle hang on the walls. Between the two windows there is a slit drum (Big Bom), and scattered all over the room are cymbals, a metalophone, singing bowls, and chimes. A mattress has been placed beside the door – it is important to have many different ways to lay down or position patients for therapy.

A video camara with the appropriate software is available for a comprehensive documentation of therapy processes. The video and film material
is mainly intended for follow-up and evaluation of therapies; in addition, this is an ideal way to record the joint musical encounter and make it transparent to family and staff members likewise.

I provide 28 weekly therapy units (single sessions) for a total of ca. 12 inhabitants. Flexible therapy blocks have proved to be suitable – after 4, perhaps 6 or possibly even 11 months I conclude one therapy phase and start with other children or adolescents in turn. Short-term developments and changes are rare; the desired results require a long period of getting acquainted and creating some familiarity between patient and therapist.

I do not want to take the lead with the children and young patients but rather accompany them on their highly individual way. The language of music helps me to adapt to their communicative level; accepting their current condition, I try to build up a relationship which may be the basis for development, autonomy and mobilisation.

Niklas (names of patients mentioned from here on have been changed for reasons of data protection) is lying on his back on the piano. In this position he is able to kick his legs. His motoric abilities for hand/arm movements are very limited due to severe spasticity. I start the session with his welcome song, and he joins in with abrupt kicking movements. I take his tempo up and follow his movement phases and breaks with my musical phrasing. Niklas starts to “dance” and thus becomes the conductor of our joint musik-making.

All behaviour in an interpersonal situation constitutes some kind of message (see Watzlawik, 1969). A head movement, a smile or smacking sound, the lifting of an arm or even a tiny finger movement can be an
attempt to come to an understanding with oneself or the environment. In the music therapy encounter I try to take up such invitations on a musical level – responding to them with my voice or an instrument and thus making them audible. The patient can feel that the music ringing out like this is directed towards him exclusively, and that he himself can modify and influence it.

**FIGURE 3. Playing and singing together**

An encounter with children and adolescents is possible even if any motoric activity seems impossible. The breathing of each human being has the quality of a personal expression; consequently, I can take it up and reflect it in an improvisation.

A preliminary significant objective in applied music therapy is to develop auditory attention, i.e. an ability to turn to acoustic stimuli and perceive them consciously. Possible reactions from children and adolescents must
be observed exactly – changes in facial expression, the turning of a head or a pause in breathing can be indications of auditory attention.

**Paul**, three years, is lying on the mattress, wrapped in a snake pillow. His breathing is calm and regular. I sing a pentatonic 5-note motif for him. After a short time his breathing rhythm changes, and he stops breathing for a moment at the end of each musical phrase.

Whenever the movements of children and adolescents can be integrated in instrumental music-making, they are no longer merely passive receivers of auditory signals; a close combination of sensory and motoric functions emerges which can give children and young persons a feeling of authorship, of originating their own activities and of not originating those of others (see Schumacher, 2000). Instruments serve to make even smallest movements audible; vocal expressions gain significance in the musical context.

**FIGURE 4. Instruments and material should fit to the special needs**
A basic element of communicative skills is to perceive one’s actions as one’s own individual activity. Encounter can be experienced, and communication enhanced on this basis.

**Jannik**, 19 years, is sitting in his wheel-chair; he holds his right arm at an angle, the fist at shoulder height. He can move this arm a few centimetres up and down. At his side he has a small table with two castanets. I sing a short melody which I repeat several times, with pauses in between. During these pauses, Jannik succeeds in playing a castanet with his elbow. The effort involved is very obvious in the photo - but also his delight in this success!

**FIGURE 5.** Jannik plays castanettes

In music therapy children and adolescents can give expression to their emotions – independent of any linguistic or motoric impairments – and get a feeling for these emotions in the joint musical play. The encounter
thus becomes an encounter with a personality, the immediate self of a human being.

“You live in order to express yourself…” – in practical music therapy the inhabitants of the Lebensarche have a chance to express themselves and to experience how their utterances are heard, taken up and carried on.

“…and in doing so you enhance the world” – the way in which children and adolescents express themselves in music is an enhancement of their own world, of my work and our joint music-making, every time again!

References:

Aldridge, David: Music therapy research and practice in medicine. London, 1996

Gustorff, Dagmar: Jenseits des Wortes. Bern, 2000

Schumacher, Karin: Musiktherapie und Säuglingsforschung. Frankfurt, 1999


Watzlawick, Paul: Menschliche Kommunikation. Bern, 1969

Infos

Lebenszentrum Königsborn has 6 different institutions:

- Haus Königsborn / an NRW model institution with 39 places for the long-term care of patients with vigil coma and involutional phases
• Königsborn Clinic for Pediatric Neurology and Social Pediatrics / 40 beds – for in-patient neuropediatric and social-pediatric diagnostic investigation
• Lebensarche Königsborn / resident institution for 50 children and adolescents with serious multiple handicaps
• Kindergarten Königsborn / day care centre for 61 young children with multiple impairments and a logopedic unit
• Sozialpädiatrisches Zentrum Königsborn / Day care centre for treatment of 1500 (p.a.) children and adolescents with a variety of development impairments and handicaps
• Schule für Kranke Königsborn / school for 57 children and adolescents (residents at the Lebensarche and in-patients of the clinic)

ADDRESS: Zimmerplatz 1
D-48087 Unna

CONTACT: Gemeinnütziger Verein (non-profit association) Lebenszentrum Königsborn
Manager: Lothar Schwuntek phone: +49-2303-9670 241
Director, Administration: Eckehard Lategahn phone: +49-2303-9670 101
Lebensarche Königsborn
Director, Education: Uwe Wandersee phone: +49-2303-9670 504

INTERNET: www.lebenszentrum-koenigsborn.de

INFO BOX I The children, adolescents and young adults from 0 to 24 years who are residents at the Lebensarche Königsborn suffer from

• craniocerebral injury trauma
• sensomotoric and mental retardation
• muscular dystrophy
• apallic syndrome after reanimation etc.
INFO BOX II

Principle of normalisation according to Bengt Nirje

“Normalisation as the guiding principle in social politics and administration, in social and educational activities and as the main objective governing the relief system for people with handicaps means: Citizens with or mental or physical or emotional handicaps shall be able to lead their lives in a way analogous to that of people without handicaps. In short: a life as normal as possible.” (THIMM 1995, p.2)

A german version of the article „Man lebt, um sich auszudrücken, und indem man es tut, bereichert man die Welt“ was published in „Musik und Gesundsein“ 4, 2002, 4-6

This article can be cited as: Thoms, K. (2003) „You live to express yourself, and in doing so, you enhance the world“ (Henry Miller). Music Therapy Today (online), February, available at http://musictherapyworld.net
On behalf of the organizers of the 6th European Music Therapy Congress, we would like to welcome you to meet your colleagues in Jyväskylä, Finland to discuss and discover the latest happenings in music therapy.

The theme of the congress is “Many Faces of Music Therapy” by which we aim to continue the diverse approach of the previous European congresses concerning research, education, theory and clinical practice.
Jaakko Erkkilä qualified as a music therapist in 1990 at the University of Jyväskylä, Finland. He has worked as a clinician in many institutions and in private practice as well. His experience includes work with various diagnostic groups including psychiatric patients, people with learning disabilities and children suffering from neurological problems. He gained his doctorate in May 1997 and since the beginning of August 1997 he has held the post of professor of music therapy at the University of Jyväskylä. Jaakko Erkkilä was appointed to the post of professor of music therapy permanently on May, 2002, at the University of Jyväskylä.

Currently his main activity is running the masters program in music therapy. He is also the head of the music therapy clinical training, which is carried out at the Eino Roiha-Institute in Jyväskylä.

He is the vice-president of the EMTC (European Music Therapy Confederation) being responsible for the Northern Europe region.

His research interests are concentrated on the theory of music therapy (from a psychodynamic perspective), qualitative research of clinical processes, music therapy improvisation, and on music technology applications in music therapy.

When he has time, he takes his accordion and plays traditional Finnish folk and dance tunes. Then he reminisces longingly about his past as a dance musician.

jaakko erkkilä, ph.d.
professor, department of music
FIN-40014 university of jyväskylä,
tel. +358 (14) 2601 351
e-mail: jerkkila@cc.jyu.fi
organizing and program committee

esa ala-ruona (finland)
david aldridge (germany)
jos de backer (belgium)
jaakko erkkilä (finland)
petra kern (germany)
kimmo lehtonen (finland)
hanne mette ochsner ridder (denmark)

congress secretariat

ms satu julin
department of music, P.O. Box 35 (M)
FIN-40014
University of Jyväskylä.
tel. +358 14 26 01 361 fax +358 14 26 01 331
e-mail: sjulin@cc.jyu.fi
http://www.jyu.fi/musica/

congress bureau

TAVI congress bureau
ms anja hakkarainen
papinkatu 21
FIN-33200 Tampere
tel. +358 3 233-0440 fax +358 3 233 0444
e-mail: anja.hakkarainen@tavicon.fi
wednesday, june 16

14.00-18.00 pm  conference office open for registration

19.00-19.30 pm  opening of the congress

jos de backer,
president of the european music therapy confederation

jaakko erkkilä,
chair of the congress

19.30-20.15 pm  keynote I
kimmo lehtonen: “crystalized musical moments in life stories. an application of prokoff’s auto-biographical method in music therapy”

20.30– concert “werner brothers"
Thursday, June 17

09.00-09.45 am keynote 2
Julie Sutton: “Hidden Music” an exploration of silences in music and music therapy

09.45-10.30 am keynote 3
Petra Kern: “Making Friends in Music”: including children with autism in interactive play

Coffee break 10.30-11.00 am

11.00-12.00 am paper session 1

12.00-12.45 pm paper session 2

Lunch 12.45-14.15 pm

14.15-15.15 pm paper session 3
Symposium I • Music Technology/Computer Aided Music Therapy
Symposium II • Hermeneutics and Phenomenology

15.15-16.00 pm paper session 4
Symposia I and II

Coffee break 16.00-16.30 pm

16.30-17.15 pm paper session 5
Symposia I and II
friday, june 18

09.00-09.45 am **keynote 4**
hanne mette ochsner ridder: “when dialogue fails – music therapy with elderly with neurological degenerative diseases”

09.45-10.30 am **keynote 5**
bent jensen: “the principle of polarization used in working with schizophrenic patients”

coffee break 10.30-11.00 am

11.00-12.00 am **paper session 6**
12.00-12.45 pm **paper session 7**
lunch 12.45-14.15 pm

14.15-15.15 pm **paper session 8**
symposium iii • music therapy and gender
symposium iv • students symposium

15.15-16.00 pm **paper session 9**
symposia iii and iv

coffee break 16.00-16.30 pm

16.30-17.15 pm **paper session 10**
symposia iii and iv
Saturday, June 19

09.00-09.45 am **keynote 6**
Gro Trondalen: “**significant moments**” in music therapy with young persons suffering from anorexia nervosa

09.45-10.30 am **keynote 7**
Lutz Neugebauer: “The importance of music therapy for encouraging latent potential in developmentally challenged children”

Coffee break 10.30-11.00 am

11.00-12.00 am **paper session 11**
12.00-12.45 pm **paper session 12**
Lunch 12.45-14.15 pm

14.15-15.15 pm **paper session 13**
Symposium V • evidence based music therapy
Symposium VI • The guitar in therapy

15.15-16.00 pm **paper session 14**
Symposia V and VI

Coffee break 16.00-16.30 pm

16.30-17.15 pm **paper session 15**
Symposia V and VI

19.00– **farewell ceremony**
philosophy and content of the congress

Our aim is to gather music therapy clinicians, students, educators and scholars together from all around Europe.

The congress intends to respect the diversity of the profession in Europe with regard to the different schools, frameworks, models, and perspectives. By doing so, we hope to be as attractive as possible to the whole music therapy community, no matter where in Europe people are coming from.

We also have some special emphases. We want to be open for new ideas and even create some new practices. First, we want to invite “fresh” keynote speakers to give new people a chance to present their work and ideas. Four out of six keynote speakers are women, which I think is quite a dramatic change to previous congresses.

The keynote speakers represent the latest and most brilliant know-how in their specific fields of expertise, five of them will have doctoral qualifications by the time of the congress. Most of them are both clinicians and researchers.

Another new thing is that we will include symposia where carefully selected topical themes will get specific attention.

The topics of the symposia are “music technology/computer-aided music therapy”, “music therapy and gender”, “evidence-based approaches”, “phenomenology and hermeneutics”, “the guitar in therapy” and a “student symposium”.

Symposia will take place in the afternoon sessions. You are also invited to submit ideas for symposia including a list of participating speakers and a moderator when we make the call for papers.
Modern technology has brought plenty of new possibilities for music therapy. It has made musical expression possible even for those who are most severely disabled. In addition, music technology can be utilized when analysing musical improvisation or just producing music in a rich way. However, music therapists are sometimes conservative and reluctant to utilize these possibilities. This symposium, stressing the role of modern technology, intends to share information, to share experience, to present the latest applications, and finally, to educate music therapists to adopt new technology as well as to reduce the biases towards it. Finland is famous of its innovations in technology. So, it is not by chance that the role of technology is one of the concerns of this congress.

All around Europe, gender issues have been in the forefront of recent discussions.

It is true also within music therapy, where primarily female music therapy researchers have paid attention to this topic. The discussion, and the research on the topic is important, and as we know, equality between men and women depends a lot on the culture in which we are living.

Those, who are helping people (therapists) must be aware about gender issues and contribute to the reduction of imbalance whenever possible by means of their clinical work as well in their research activities.
evidence-based music therapy

The third symposium, evidence-based music therapy, is more than topical because of its general importance in the whole field of health care delivery throughout Europe. To be part of the official health care system, each form of treatment must show its importance based on general and common criteria within health professions.

This principle concerns music therapy as well. Treatment effects have to be demonstrated. In an evidence-based approach this means that the effect of music therapy must be proved by utilizing the methods adopted mostly from positivistic tradition.

However, this must not deter us from the debate about what counts as evidence in music therapy and how this can be utilised in assessing the merit of our various practices.

There is a lot of work to be done when accommodating music therapy to evidence-based standards, especially when taking into consideration that many researchers in music therapy adopt qualitative research strategies.

We have to pay attention to an evidence-based approach if we are to integrate music therapy within the varying health care delivery systems in Europe.
phenomenology and hermeneutics

To respect an established European tradition, one symposium is called “phenomenology and hermeneutics”. It is still important to maintain and develop reflective and interpretive approaches that have always had important roles within music therapy. In a way, by including this symposia in the congress, it wants to stress the importance of various frameworks as well as to support the traditional trends of thinking and research.

Although we have to answer the requests society is asking of us, we must also respect, maintain, develop and retain our old traditions and lines of thought and investigation, otherwise we are in danger of being cut off from our roots and lose that what history has given to us.

student symposium

A new idea is to include a specific student symposium in the congress. In previous congresses, not much attention have been paid to students and their needs. Having listened to students, we will attempt to redress that lack. On the other hand, all around Europe the amount of music therapy students is growing due to new training programs and even new countries who are taking their first steps on the field. Students are very active and have established a new student organization under the head organization (European Music Therapy Congress) and we want to place a special emphasis on to this issue.

Students are the music therapists of tomorrow and we want to give them the opportunity to hear the best research and practice while they are still young in their careers.

The basic philosophy of this congress is also to make the participation possible for those who have not much money. We try to arrange cheap accommodation (especially for students) and keep the congress fees moderate for those who have not much money.

This concerns also those of the participants living in those European countries where the costs of living is not as high as it is in Finland.
general points of view

Of course we have traditional paper sessions included in the congress as well. We have different sections for the papers, and they are:
- theory
- clinical practice
- research
- methods and approaches

We expect to receive plenty of abstracts from each of the areas. When the question is about therapy profession, it is important to make room for the practical topics as well.

We hope to receive many clinical case studies from different diagnostic populations. Thus, the congress will be of great importance for clinicians who can on the one hand present their own clinical cases to others, on the other hand, to listen to the presentations of others and to participate in the congress.

We want to keep the four sections open so that it is up to what is in the abstracts as to how the paper sessions will be formed.
The 6th European Music Therapy Congress is to be held at the University of Jyväskylä in Finland. The venue for the congress in the University buildings is an architectural treat for us all. While the last world conference in Oxford, England celebrated the traditional architecture of an English setting, we have the chance to experience the art of building from an era closer to the present.

The campus site is a mixture of buildings from varying eras of Finnish architecture. The main congress rooms will be in the University buildings designed by Alvar Aalto.

Aalto’s approach was to integrate people, nature and building. Such an integrative approach is the underlying philosophy of the congress, where we offer an opportunity to greet the many faces of music therapy. This also reflects the current movements in health care delivery that no longer talk of alternative medicines, nor complementary medicine, but integrative medicine.
We have a variety of buildings that we can use, all of which represent the beauty of Finnish architecture located within a marvellous landscape. Don't be put off by the winter scenes, in June the snow has disappeared and we will be in the season of the midnight sun.

A feature of the buildings is the attention to detail. We have function together with an aesthetic. In this sense, the venue is ideal for music therapy, where music is used in a functional sense as therapy but still retains its aesthetic. Indeed, the aesthetic is in the application. This reflects the intentions of alvar aalto's architecture.
Alvar Aalto (1898 - 1976) was born in 1898 in the village of Kuortane, situated between the lake country of central Finland and the flat farmlands of the western province of Ostrobothnia. When Aalto was five, his family moved to Jyväskylä, a town that closely associated with his name. It contains more of his buildings than any other place in the world. He designed 70 buildings for the town and its surroundings, 37 of which were realised as actual buildings.

Although his early work borrowed from the neoclassic movement, he eventually adapted the symbolism and functionalism of the Modern Movement to generate his plans and forms but moved beyond this to his own particular style.

Aalto’s mature work embodies a unique functionalist, expressionist and humane style, successfully applied to libraries, civic centres, churches, housing and to the building we will be using, the university.
The modernist movement in architecture emphasized function. It attempted to provide for specific needs rather than imitate nature. We see this in the German Bauhaus approach. The architect Walter Gropius was chosen to head a new institution which would help rebuild Germany after the First World War and form a new social order. One way was through a new social housing for the workers. Bauhaus architects rejected “bourgeois” details such as cornices, eaves and decorative details. They wanted to use principles of Classical architecture in their purest form, without ornamentation of any kind. Buildings had flat roofs, smooth facades and cubic shapes. Colours were white, grey, beige or black. Floor plans were open and furniture was functional. Walter Gropius and other Bauhaus leaders migrated to the United States where the former Bauhaus architecture became the International style.
The two pictures here are taken of the main building lobby. This is where we will enter for the congress and from here we can access the principal lecture halls. As you see, the lobby is spacious and welcoming. Apart from this spaciousness, there is a connection to the outside world through the extensive use of glass in the walls. The campus is located in woods and we can experience their presence even when we are within the building itself.

Aalto’s style of functionalism also rejected romantic excess and the monotonies of neoclassicism. Although he borrowed from the International Style, he utilized texture, colour, and structure in creative new ways. He refined the generic examples of modern architecture that existed in most of Europe and recreated them into a new Finnish architecture.
aalto was a master of form and planning, as well as of details that relate a building successfully to its users. His buildings have provided renewed inspiration in the face of widespread disillusionment with high modernism on one hand and post-modernism on the other.

Architects in Finland had been concerned throughout its history with producing buildings that could mediate between art and nature. Faced with new challenges brought about by industrialization, aalto respected his predecessors for the steps they had taken in the integration of technology with indigenous Finnish styles. He felt that their work existed as an important transition between traditional architecture and new architecture. He felt new architecture to be overwhelming in nature and unresponsive to the autonomous, informal traditions of Finnish architecture.
Instead, Aalto proposed an architecture of ideas directly attainable through sensory experience. An architecture that he hoped would humanize in the age of the machine. Such a sympathetic ideology fits well with music therapy as music therapists have noted working in the high technology environments of intensive care medicine or neurological rehabilitation. It is the humanizing factor of music therapy that is important for the healing milieu.

A principle of design is that the form of an article should be determined by its use and this idea brings us some way towards appreciating his work. Functionalism was a phase in Aalto’s career, a step on the way to his expression of the organic relationship between man, nature and buildings. It was Aalto’s ability to coordinate those three components that discloses the beauty of his work. Aalto spoke of his “building art” as a synthesis of life in materialised form. Anthroposophist’s talk about architecture as frozen music.

We also know from the traditions of sacred architecture in Europe that there is particular resonance and fit between the architecture of a building, the form of the liturgy and the form of the music that is used for rituals in such a setting. Thus we have an ecology of “formal” ideas that share a common “architecture”.

A challenge for us as music therapists is to help design healing environments where the aural will be as important as the visual.
aalto realized that architecture is inherently an instrument of communication, and therefore he relied on built elements themselves, rather than symbolic or literal devices, to accomplish his objectives. The relationships and attitudes about harmony and unity that aalto conveys exist through the architecture creating a compelling building with an undeniable message as we will see as we enter the congress to register.

In the 1930’s aalto was accredited as the supreme master of functionalism, a genre that he was soon to walk away from in his pursuit of artistic harmony through a synthesis encompassing people, their environment and the buildings in which they live.

We have this ecological concept already in music therapy. Our next step will be to apply it in other healing environments. In this congress we will have the opportunity to explore the many possibilities, as well as the many faces, of music therapy.

david aldrige
Breath in Healing

David Aldridge

Abstract

Many healing traditions have used breath as vehicle for healing. Two specific healing initiatives are used as illustrations of how breath is both a subtle organizing property and a material manifestation. Singing, in the context of music therapy, organizes intentionally the physiological abilities of another person as they recover from coma. The second healing initiative is that of Qigong Yangsheng for the treatment of asthma. Here breathing is also used as an intentional activity, this time by the patient to improve his or her own breathing abilities and to heal what is essentially a breathing problem, the material manifestation of air-flow.

Breathing is a central principle in communication and healing and forms the basis of many therapeutic disciplines. Perhaps we can encourage our clinician colleagues toward be aware of their breathing and be less aware of their machines.
“Subtlety produces beauty; it is subtlety which is the curl of the Beloved”

Sufi Inayat Khan, The Bowl of Saki, p12. (Khan 1979)

“It my be said that breath is the chain that links body, heart and soul together, and is so important that the body – so loved and cared for, kept in palaces, its slightest cold or cough treated by doctors an medicines – is of no more use and cannot be kept anymore when the breath is gone”.

Sufi Inayat Khan, Sufi teachings. The art of Being, p 71 (Khan 1991)

Introduction

Breath in Healing may appear to be a simple title, but like all things concerned with the term “healing” the concept is complex and fraught with challenges. One of those challenges is that, like the term energy, breath is used as both a literal truth and a metaphor. Many healing traditions have used breath as vehicle for healing but breath itself is more than the commonly understood gaseous compound. Indeed, we really have to talk about the process of breathing to begin to understand what breath is.

We another conceptual problem too with healing; while healing is understood to have occurred, evidence for demonstrating that healing has occurred is dependent upon the observer or the participator, and what actually has done the healing is elusive to demonstration.

When we come then to talk about the breath of healing, there is room for confusion. In the latter part of this paper I will use two specific healing initiatives that are based upon breath as illustration of how breath is used both as a subtle organizing property and in its material manifestation. The first is the use of breath through singing to intentionally organize the
physiological abilities of another person as they recover from coma. This is literally the intentional use of breath to heal realised through a particular therapeutic form, which is improvised music. A fundamental property of breathing is that it has rhythm. In musical terms, rhythm has to have the property of intention otherwise it would be simply cyclic repetition or pulse. The second healing initiative is that of Qigong Yangsheng for the treatment of asthma (Reuther and Aldridge 1998). Here breathing is used as an intentional activity, this time by the patient to improve his or her own breathing abilities and to heal what is essentially a breathing problem, the material manifestation of air-flow.

**Breath, the beginning and ending**

Life begins and ends with breath. Slight bodily changes are brought about by alteration in the mechanisms of breath. In addition, mental changes are also influenced by breath. Our general condition of well-being is dependent upon the rhythmic cycles of breathing within us. Similarly, emotions change the rhythm of breath and when we become over-excited then we lose control over the breath. By gaining control of the breath then we gain mastery of mind and body. Not only that, we also establish a connection with the world around us, of which we are part, through the breath. However, such a basic activity, breathing, has become transparent to us and we often take it for granted until the moment that we becomes sick.

There is a variety of qualities to understanding the breath. It has volume, which we will see late in the asthma study; it needs to be centralized to be certain; the breath must be far-reaching to be strong; it must be rhythmic to achieve balance, which we will see in the music therapy study of
Breath in Healing, and it must have depth to encourage strength. These qualities of breath can be trained and have ramifications for health. Furthermore, these qualities are also necessary for the efficacy of the healer.

A deeper understanding of breath is concerned with its subtle qualities. Khan (Khan 1991) defines how breath shows the nature of man. The person who works with material things and expends greater physical energy has a noisy breath, like animals. The breath of a thoughtful person is rhythmic and becomes fine. Even finer breath leads to enhanced perception and to spiritual understanding. In this Sufi sense, breath is

“...that vast current running through everything, that current which comes from the Consciousness and goes as far as the external being, the physical world” (p67).

If we also consider the wholistic nature of healing, then it is the breath that links body, heart and soul together.

**Healing and language**

Explanations given for how healing works are various; paraphysical, magnetic, energetic, psychological and social. The main explanatory principal is that there are energies which are transformed by the agency of the healer producing a beneficial influence upon the ‘energy field’ of the patient. This notion of ‘energy field’ is the sticking point between orthodox researchers (Jacobs 1989; Wood 1989) and spiritual practitioners in that if such a field exists then it should be possible to measure by physical means. The problem probably lies in the use of the word ‘energy’ which has a broader interpretation in intentional healing and is likened to organising principles of vitalism and life force that bring about a harmonising of the whole person.
The source of the word energy in the Greek is ergon meaning to work in a physical sense and to be active or possessed by a demon. The former is the meaning used by modern scientists, the latter by other healers. If we add the prefix en, then we have energio - to be in action; in this sense it is used by modern spiritual healers to suggest dynamic forces that are channelled or set in motion by the healer, or the patient. These forces may work directly or they may be forces that organize other forces into patterns. Thus we already have some confusion (see Aldridge 2000).

Ancient systems of healing were based on the dynamic notion of energy (Leskowitz 1992). Fire energy; brings warmth through the principle of motion. Hidden energy, which is air, is the sustaining energy and the activator of fire energy that uses as its vehicle the blood stream, thereby maintaining the chemistry of life and conveying the vital energies of the body. In addition there are three forms of energy distribution. One, through the seven energy centres that serve as points of reception and distribution throughout the physical body. Two, through the seven major glands of the endocrine system; and three, through the nervous system. Restriction or inhibition of the free flow of these energies creates an imbalance or disharmony in the others. Health can be restored by releasing the cause of the blockages, also through the application of specific musical tones, to restore the flow of energy.

If we look at traditional Indian forms of medicine, Aryuveda and Unani (Greco-Arabian), we have a vitalist epistemology based upon the physician as activator of the seven natural principles which administer the body (elements, temperaments, humours, members, vital breaths, faculties and functions) (Verma and Keswani 1974). In this sense, after Hippocrates, “Nature heals; the physician is nature’s assistant”. Breath is an
important factor in activating the patient. Vitality itself derives from viva, “Let him live”. The breath carries such a living force. Breath and spirit share the same root, in Latin spirare, which later becomes spiritus, life breathed as the Holy Spirit. Life has the quality of inspiration and is heard in biblical texts as “I am the Breath of Life”. Similarly the Greek anemos and the Latin anima are translated as wind and breath. Thus we have the ideas of vitality and animation being achieved through the inspiration of the breath, or pneuma in Unani medicine, which is the conveyor of the spirit and activates, through its various parts, particular systems. It is Breath, in the Christian Bible Old Testament, that animates the dry bones with vitality such that they love. Today Aryuvedic medicine, yoga and some forms of Traditional Chinese medicine still utilise the regulation of breathing as an important factor in healing.

Benor has made a detailed study of healing initiatives (Benor 1991) and offers a definition of healing that succinctly combines most of the modern concepts found in intentional healing. Healing is “...the intentional influence of one or more persons upon a living system without using known physical means of intervention” (p9). The etymological roots of intention are in the Latin tendere that means a stretching of the mind to become attentive, with expectation. This extended attention of the mind is a dynamic process of shifting awareness to the other as an offer of contact. It is the breath that is the vehicle for this reaching out.

Influence, from the Latin influere, is a flowing in. (Influenza, from the same root, is a malady caused by the flowing in, literally in-fluence, of heavenly bodies). Healing, from this perspective, is the offer of a dynamic process, the stretching of the mind of the healer that flows into the other person on the influential breath. Conversely, we can speculate...
about what we project into the world on the out-flowing breath. In this way we understand others, and are ourselves understood, by the way in which we breathe. At its simplest and coarsest, we know when another person is happy, sad or anxious through their breathing. Beyond that, there are levels of subtle understanding inherent in the projected breath. This has ramifications for counselling, therapy and for all medical encounters (Aldridge 1989a; Aldridge 2000a).

If we return once more to the roots of the everyday words that we use in medicine then we see that these spiritual and psychological considerations are not strange. Patient is derived from the Latin pati, which is to suffer and patiently endure. Doctor is the teacher who discerns from the Latin docilitas. Therapy is attentive support from the Greek therapeutikos. Therapist and doctor accompany the patient in their suffering along the way, with the responsibility of the healer to reach out to the patient, and the doctor to discern and to teach. Such a stance is not solely concerned with cure; there are also the possibilities of relief from suffering and comfort for the sick. It is in this way that one reaches out to the other in terms of breath. Indeed, we can coordinate our breathing with others. This happens when we become intensely empathically involved with another person and can be completely unconscious.

The same process of empathy can be used intentionally by healers to control breathing and impose calm upon a situation or enliven a situation. It is this change of conscious, through control of breathing that is central to the healing process. We will see this later in the process of singing in music therapy and in Qigong Yangsheng. Indeed, when I teach meditation to beginners, it is the injunction “Be aware of your breathing” that is the next step (Aldridge 1987) after “Allow our eyes to close”. These two
injunctions are concerned with focussing the senses. Reducing visual input and concentrating on the breath.

The therapeutic approaches I will be discussing here are based upon natural breathing cycles. Cycles that become rhythmic when intended. Second, the endeavour of healing, through the intentional action of the healer, is to extend the attention of the sufferer beyond a simple cycle to that a broader perspective. This makes sense systemically, in that we encourage patients to couple with a broader ecology, literally to bring themselves into balance with their environment. This may also be expressed as putting a persons’ problems into perspective. Whatever explanation we choose to use, it is based on breathing and involves a change of consciousness (Aldridge 2000b).

A change in consciousness perspective adds another dimension to those therapies that are considered to be psychotherapies in that the vehicle for their efficacy may be a controlled environment of breathing where a transference does take place, but this is a transference of consciousness through breath, not cognition. Indeed, the intentional control of breath is the basis of achieving changes in consciousness in various spiritual traditions. As Grof (Grof 1985) suggests, the traditional biographical model used in psychoanalysis is inadequate to describe the broad spectrum of important experiences that became available through breathing and movement techniques.

An illustration that breathing is not simply a material phenomenon can be demonstrated by the fact that athletes are trained to breathe and move strenuously transporting vast volumes of air through respiration. This control of breath is intended and serves to facilitate their physical bodies. No change in consciousness, however, is intended by such coarse breath-
ing. Yet, we have varying spiritual traditions where an intentional control of the breath achieves changes in consciousness. The key to understanding the breath of healing cannot lie in the exchange of gases. Such exchanges are measurable but simply too coarse to understand changes in consciousness. To understand the influence of breath we must as observers direct our understanding elsewhere. Intention to alter breathing is not the sole key, we need to understand the purpose of that intention. Human purposes are not measurable, although the consequences of those purposes may be predicted and they can be discerned through qualitative research (Aldridge 1992; Aldridge 1993b; Aldridge 1996; Aldridge 2000b).

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 (Aldridge 2000b).

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. In relationship we foster a return to those ecological connections. And it is breath that forms the basis of relationship through rhythm (Aldridge 1996).

Singing then is an appropriate form for achieving empathy and changing consciousness. Through singing together we enter a common ecology of breathing. It is a powerful medium for expressing a variety of human emotions in all their subtleties and complexities (Aldridge and Magill 2002; Magill 2002).

Music therapy with coma patients

Intensive care treatment is a highly technological branch of medicine. Even in what may appear to be hopeless cases, it can save lives through the application of this modern technology. However, albeit in the context of undoubted success, intensive care treatment has fallen into disrepute. Patients are seen to suffer from a wide range of problems resulting from
insufficient communication, sleep and sensory deprivation and lack of empathy between patient and medical staff. As I mentioned earlier, a basis for empathy is a common pattern of breathing. Many activities in an intensive care situation appear to be between the unit staff and the essential machines, i.e. subjects and objects. To a certain extent patients become a part of this object world. They lose that intentionality necessary for life becoming disoriented in time and space; they lose the rhythm of breathing and consciousness (Aldridge 1993a).

A music therapist began working with coma patients in an intensive treatment unit. Five patients, between the ages of 15 and 40 years, and with severe coma (a Glasgow Coma Scale score between 4 and 7) were treated. All the patients had been involved in some sort of accident, had sustained brain damage and most had undergone neurosurgery (Aldridge 1991a).

The form of music therapy used here is based on the principle that we are organised as human beings not in a mechanical way but in a musical form; i.e. a harmonic complex of interacting rhythms and melodic contours. To maintain our coherence as beings in the world then we must creatively improvise our identity. Rather than search for a master clock that coordinates us chronobiologically, we argue that we are better served by the non-mechanistic concept of musical organisation. Music therapy is the medium by which a coherent organisation is regained, i.e. linking brain, body and mind. In this perspective the self is more than a corporeal being.

Each music therapy contact lasted between eight and twelve minutes. The therapist improvised her wordless singing based upon the tempo of the patient’s pulse, and more importantly, the patient’s breathing pattern. She
pitched her singing to a tuning fork. The character of the patient’s breathing determined the nature of the singing. The singing was clearly phrased so that when any reaction was seen then the phrase could be repeated.

There is a hierarchy of musical organization from pulse, to metre, to rhythm that becomes itself organised into segments of time as phrasing. Phrasing can be understood by any listener but it is almost impossible to measure. We can see when exactly the notes occur but what organizes them is elusive. As in the process of consciousness, the property of organization is non-material. At the basis of all these activities, starting with pulse, is breath. It is the assessment of intentionality of breath within the pulse, which give pulse their subtle qualitative dimensions that is central to some diagnostic traditions.

There were a range of reactions from a change in breathing (it became slower and deeper), fine motor movements, grabbing movements of the hand and turning of the head, eyes opening to the regaining of consciousness. When the therapist first began to sing there was a slowing down of the heart rate. Then the heart rate rose rapidly and sustained an elevated level until the end of the contact. This may indicate an attempt at orientation and cognitive processing within the communicational context (Aldridge 1996; Aldridge 2000b). EEG measurement showed a desynchronization from theta rhythm, to alpha rhythm or beta rhythm in former synchronized areas. This effect, indicating arousal and perceptual activity, faded out after the music therapy stopped.

Some of the ward staff were astonished that a patient could respond to such quiet singing. This highlights a difficulty of noisy units such as these. All communication is made above a high level of machine noise. Furthermore commands to an ‘unconscious’ patient are made by shouting.
formal injunctions, i.e. "Show me your tongue", "Tell me your name", "Open your eyes". Few attempts are made at normal human communication with a patient who cannot speak or with whom staff can have any psychological contact. It is as if these patients were isolated in a landscape of noise, and deprived of human contact.

A benefit of the music therapy was that the staff were made aware of the quality and intensity of the human contact. In the intensive care unit environment of seemingly non-responding patients, dependent upon machines to maintain vital functions and anxiety provoking in terms of possible patient death, then it is all too often a reaction by the carers to withdraw personal contact and interact with the machines. This is further exacerbated by a scientific epistemology which emphasizes the person only as a material being equating mind with brain.

A period of calm was also recognized as having potential benefit for the patient. What some staff fail to realise is that communication is dependent upon rhythm, not upon volume. We might argue that such unconscious patients, struggling to orient themselves in time and space, are further confused by an atmosphere of continuing loud and disorienting random noise. For patients seeking to orient themselves then the basic rhythmic context of their own breathing may provide the focus for that orientation. This raises the problem of intentionality in human behaviour even when consciousness appears to be absent.

We can speculate that the various body rhythms have become disassociated in such comatose states. The question remains then of how those behaviours can be integrated and where is the seat of such integration. My answer would be that it is breathing that provides the fundament of
human communication upon which that coherence of being called health is built.

Lucanne Magill, working at Memorial Sloan Kettering Cancer Center in New York, says that similar in concept to the work done in the intensive care unit with trauma and head injured patients, music therapy in an intensive care unit in a cancer hospital setting also achieves meaningful results. In this setting music therapy is multi purposeful, offering sensory experiences that can reach the patient and also provide an inspiring medium through which family members can express and be in closer contact with the patient. The presence of singing and acoustic instruments, while offering a more vivid and complex sound environment against the droning effects of the machines, seems to immediately influence persons in the environment- altering mood, focussing activities as well as drawing attention to, regulating and enhancing breath flow. The presence of live music also deepens awareness of the human element amidst the necessary machinery, reminding those present of the individual being cared for, the opportunity to reflect on the existential meaning of one’s own life and the commonalities we share as people throughout time. Music, especially singing, has a way of restoring this focus and reuniting people in the ICU as well as any environment. These effects, as mentioned previously, significantly influence staff in meaningful ways, enhancing their sense of purpose and providing a milieu in which they can relax and relate.

Central to the act of breathing, and in terms so healing, breathing together, is the concept of performance in the subjective now (Aldridge 2000a). The coordination of human activity that lends itself to the coherence that we experience of being healed is dependent upon a temporal
concept. Time is structured and breath is the scaffolding of time in which the present is constructed. The construction in time, that we call now, when extended, is the basis of cognition. That is how music therapy works, it offers a temporal structure for events that facilitates cognition.

At the heart of this temporal coherence is the rhythm of breathing. Through the control of breathing we achieve coherence. For those disorientated in time, then they become oriented through that non-material activity of breathing, although the material necessity of gaseous exchange is present. This is why some scientific approaches appear to be coarse as they concentrate on the coarse elements of breath not on the subtle qualities, and why some of us refer to the fact that patterning is what lies behind the explication of the pattern. We shall see later that for asthma patients, an intentional control of breathing is beneficial even at the coarse objective level of improving airway impedance.

**TIME AND 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; that is, intention. 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. Rhythm demands intention. Patients in intensive care are often prisoners of mechanical time. They have not a chronic illness but a kairotic illness (Aldridge 1996). While the various physiological elements may be in place, initiation of those activities to promote coherence cannot take place, Acts cannot be brought into being and therefore
purposes remain uncompleted. In this way, being in a coma is not something that makes sense, it is something that no longer makes time. Sensory abilities may well be present but they have no context of coherence. 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. Mentation for the coma patient is a kairotic process not solely understandable as chronology. De-mentionation is the dis-coupling in kairotic time of physiological events. Achieving consciousness then is becoming in time, and this is facilitated by the intentional breath of the healer. At other levels of consciousness, this may be initiated by the healer or may be initiated by the patient, as we will see below.

Qigong Yangsheng in the management of chronic asthma

Chronic asthma is a common problem in the Western industrialised countries causing a great deal of incapacity. It also a disease intractable to modern day treatment initiatives. Essentially the problem is one of extreme difficulty in breathing, there is an impedance of the air ways such that breathing is severely restricted and this can lead to death. Any form of therapy that concentrates on improving the capacity to breathe is important. Qigong has the potential to make such an influence on breathing capacity through the activity of mastering breathing itself. Changes in this breathing capacity can be simply measured through an increase in peak expiratory flow rate (PEFR) of the breath.

In a qualitative study by de Vito (DeVito 1990), adult patients with chronic asthma were asked to recall their feelings associated with sensations of shortness of breath during hospitalisation. Several themes
emerged that dominated the experience including fear, helplessness and loss of vitality. From this we know that breathing while being a physical problem also has ramifications for mental well-being when the core of existence is threatened. My further argument further would be that a sense of being healthy, from a holistic perspective, is dependent upon the many subtle layers of breath.

A second concept is “Gong”, meaning exercise in the sense of a permanent, diligent and persistent practice. Embodied in this meaning is the idea “to master a technique”. Thus we have Qigong as a mastery of the vital force or a training in practice of using the life energy. Qigong is an integral part of Chinese Medicine. The word “Qigong incorporates two concepts. The first is “Qi” meaning breath, steam, mist, breeze and energy. As we have seen at the beginning of this paper, definitions are elusive, meanings are subtle. We used the definition of “vital force” or “energy of life” (Reuther and Aldridge 1998). The definition of terms is complex but that is the challenge of research understandings and is surely a capacity of human understanding, to discern complex meanings. It also denotes a component of the qualitative research approach where we concentrate on the meaning of phenomena for both practitioners and patients (Aldridge 2000b; Heath 2000).

“Yangsheng” means care of life, so we can readily understand that Qigong Yangsheng will be a therapeutic form of practice designed to care for life energies. We find such definitions in other healing traditions too that focus on breathing and mastery. In this case, the initial training is concerned with a mastery of the coarse breath although, as in other practices, the influences become more subtle.
THE STUDY

Thirty adult patients, 23 females and 7 males, of varying degrees of asthma severity, were studied as a series of single-cases. When we do not know the “dose-response” of this therapy, nor the conditions necessary for optimal therapeutic efficacy, there is no sense in embarking upon a controlled trial (Aldridge 1991b; Aldridge and Pietroni 1987).

Peak flow measurement, use of prescribed medication, diary accounts of symptoms (sleeping through the night, coughing, expectoration, dyspnoea and general well-being) and exercise were monitored through the successive phases of treatment, exercise and practice. There was a follow-up period one year after the study had begun such that measurements could be made to avoid seasonal fluctuations.

The 15 expressive forms of Taiji-Qigong developed by Professor Jiao Guorui were taught (Jiao 1995). These exercise can be done standing or sitting and are, therefore, adaptable to the physical strength of the patient. They are easy to learn, may be modified, are versatile and balanced, and may be practiced out of sequence. In this educative and experiential approach, a definitive exercise leading to a special effect is of less important than the positive effect brought about by the harmonious unity of physical movement, mental calm and naturally flowing breathing. The Qi-Gong instructors were all physicians personally trained in this method.

IMPROVEMENT

To assess the responsiveness of the peak flow measurements, then the amplitude of the peak flow rates relative to the highest value was calculated as a percentage (Boulet, Turcotte, and Brochu 1994). This percentage is the variability and correlates to the degree of severity of the disease and to the degree of inflammation in the respiratory tract (Higgins, Brit-
ton, Chinn et al. 1992). In our study, a patient was considered improved when a diminishment of 10 percent points or more in variability from the first to the fifty-second week was achieved, providing the average of the flow values remained constant or increased and the required medication use remained the same or could be reduced.

Improvement occurred more frequently in the group of exercisers than in the group of non-exercisers (p<0.01 chi square with Yates correction). There were also reductions in hospitalisation rates, less sickness leave, diminished antibiotic use and fewer emergency treatment consultations resulting in reduced treatment costs (Reuther 1997). A commitment to continuing exercise, and persistent practice, lead to improvement in breathing and this emphasises the intentional component of healing; in this case by the practitioner and patient. Objective improvement in breathing ability is dependent upon the patient’s commitment to his or her own health.

Improved pulmonary function means objectively better breathing and subjectively an enhanced feeling of well-being, including fewer experiences of entering the status “sick”. For me this is a characteristic situation where a disease is considered to be chronic but is indeed kairotic. Chronos fixes the patient within an external time and effectively removes the intentional aspect of breathing and health. Kairos emphasises the possibility of regaining intentional influence of the breath and making an impact on the disease. Kairos is literally a time of decision – to seize the moment – and this can be applied to breathing.

In this treatment approach, the patient has to take an active part in his recovery. He is not the recipient of treatment but an active participant. The learning element is an important principle in terms of prevention. We
see in this study that motivation is an important factor. Fifty percent of those engaged in the study failed to continue exercising once the second teaching course was concluded. This reflects the concerns expressed in the literature regarding patient compliance and empowerment (Webber 1990).

Conclusion

We saw at the beginning of the paper that mastery of the breath is vital. Breath is influenced by posture and movement, which we see in the Qigong study. The coarse breath is brought under control, and with this a return to the state of health. Central to this activity is the intention of the patient to be healed.

In contrast, we see in the coma study, that it is the intention of the healer, reaching out with her own breath, that balances the breath of the patient through rhythm. Through this intended breath we see an improvement in consciousness. These are but two simple examples of the breath in healing.

It leads us to conjecture that breathing is a central principle in communication and healing and forms the basis of many therapeutic disciplines, that we would perhaps be advised to encourage our clinicians towards their breath and away from their machines (Aldridge 1989).

Finally, Inayat Khan (Khan 1991) remind us:

“If a person exercises the breath and practises concentration with a scientific idea only, he soon becomes tired. If its is done with the thought of God, with the repetition of the names of God, then – by the thought of the idealized God in whom is all perfection, all
beauty, who is Friend to whom we tell our sorrows all our troubles – a happiness comes, a bliss” (p70).

In singing, we have the apotheosis of achieving the subtle breath and the bridge to other states of consciousness.

Coda

We have seen that breath has qualities and various layers of subtlety. We can discern the effects of the subtleties through scientific methods. However, we can also determine the nature of these subtleties, the phenomena themselves through qualititative research designs. This will also include breathing and healing as process. The terms we use - “energy”, “chi”, “healing”, “health” – and understandings of the relationships that they have –“ecology” and “pattern” – are embedded, and embodied, in our cultures of health care and cultures of science. A time has come where the explication of meanings through qualitative research will enhance the pursuit of scientific research through other methods.

Literature


Eine Zusammenstellung
von Studien/Veröffentlichungen
über Künstlerische Therapien
in der Akutmedizin und Onkologie

Zur Begründung der OPS-Revision
für Kreative/Künstlerische Therapien
des Runden Tisches Psychosozialer Fachgesellschaften im Akutkrankenhaus

Zur Vorlage der Begründung für die OPS-Revision von September 2002 für
psychosoziale Diagnostik und Therapie
des Runden Tisches Psychosozialer Fachgesellschaften im Akutkrankenhaus
gegenüber dem Deutschen Institut für Medizinische Dokumentation und
Information (DIMDI)

Prof. Dr. David Aldridge
Harald Gruber
Bettina Kunzmann
Prof. Dr. phil. Joachim Weis
23. 10.2002
Eine Zusammenstellung von Studien/Veröffentlichungen über Künstlerische Therapien in der Akutmedizin und Onkologie

Zur Begründung der OPS-Revision für Kreative/Künstlerische Therapien des Runden Tisches Psychosozialer Fachgesellschaften im Akutkrankenhaus

Zur Vorlage der Begründung für die OPS-Revision von September 2002 für psychosoziale Diagnostik und Therapie des Runden Tisches Psychosozialer Fachgesellschaften im Akutkrankenhaus gegenüber dem Deutschen Institut für Medizinische Dokumentation und Information (DIMDI)

Autoren:
Prof. Dr. David Aldridge, Harald Gruber, Bettina Kunzmann, Prof. Dr. phil. Joachim Weis

Herausgegeben als Manuskript zum 23.10.2002, Witten, 43 Seiten

Abstract:

Es finden sich: Abgeschlossene nationale und internationale Studien; Abgeschlossene und laufende Dissertationen; Laufende nationale Studien; Weitere Studien und Veröffentlichungen. 32 Studien/Veröffentlichungen wurden mit abstracts genannt. Die Einteilung nach EbM-Kriterien wurde vorgenommen und kann bei den Autoren, soweit nicht in der Zusammenstellung genannt, erfragt werden.

Keywords:
Künstlerische Therapien; Akutmedizin; Onkologie; Forschung; OPS-Revision;

Vorwort:
Im Sinne von Prof. Fritz Marburg, Deutscher Fachverband für Kunst- und Gestaltungstherapie (DFKGT) fruchtet die methodenübergreifende Konsensbildung und Zusammenarbeit zur Sicherung der Künstlerischen Therapien. Erstaunlich und erfreulich ist, dass es wesentlich mehr Studien gibt als vorausgesetzt. Die Autoren danken allen, die an der Zusammenstellung beteiligt waren. Es ist davon auszugehen, dass die Breite an Künstlerischen Therapien noch deutlicher zu spiegeln wäre, indem weitere Pools an Studien von den jeweiligen Verfahren (Musik-, Kunst-, Tanz-, u.a.) geöffnet würden.


Ergänzungen von Studien/Veröffentlichungen, abstracts, Einteilungen nach EbM-Kriterien einreichen unter: studien@dfkgt.de

Hintergrund:

Durch den Erfolg der Resolution zur Sicherstellung psychosozialer Versorgung in der Akutmedizin (Koordination Universität Leipzig, Sozialmedizin, Prof. Dr. R. Schwarz, Dr. O. Krauß) des „Runden Tisches Psychosozialer Fachgesellschaften in der Akutmedizin“ mit über 110 Beteiligungen von Patientenorganisationen, Fachgesellschaften und

Der Runde Tisch Psychosozialer Fachgesellschaften in der Akutmedizin hat im September 2002 eine OPS-Revision mit Vorschlägen zur Psychosozialen Diagnostik und Therapie bei DIMDI eingereicht. Mitglieder des Runden Tisches Psychosozialer Fachgesellschaften in der Akutmedizin sind: BDP (Berufsverband Deutscher Psychologinnen und Psychologen e.V.) Sektion Klinische Psychologie mit Fachgruppe Klinische Psychologinnen und Psychologen im Allgemeinkrankenhaus; BVAKT (Berufsverband für Anthroposophische Kunsttherapie e.V.); BVHK (Bundesverband Herzkranke Kinder e.V.); dapo (Deutsche Arbeitsgemeinschaft für psychosoziale Onkologie); DDG (Deutsche Diabetes Gesellschaft) AG Psychologie und Verhaltensmedizin; DFKGT (Deutscher Fachverband für Kunst- und Gestaltungstherapie e.V.); DGVT (Deutsche Gesellschaft für Verhaltenstherapie); DVSK (Deutsche Vereinigung für den Sozialdienst im Krankenhaus); E.F.N.M.U. (Europäischer Verbraucher-Verband für Naturmedizin); Verband der gemeinnützigen Krankenhäuser für anthroposophisch erweiterte Medizin; GNP (Gesellschaft für Neuropsychologie); GPOH (Gesellschaft für pädiatrische Hämatologie und Onkologie); PSAPOH (Psychosoziale Arbeitsgemeinschaft in der pädiatrischen Hämatologie und Onkologie); PSO (Arbeitsgemeinschaft Psychoonkologie der Deutschen Krebsgesellschaft); PSYSOZ in der DAIG e.V. (Abt. Psychologie und Sozialwissenschaften in der deutschen AIDS-Gesellschaft); VPP (Verband Psychologischer Psychotherapeut/innen im BDP);

Die Begründung der OPS-Revision konnte Anfang Dezember 2002 nachgereicht werden.

Das Kuratorium für Fragen der Klassifikation im Gesundheitswesen beim Bundesministerium für Gesundheit (KKG) fordert seit dem 6. März 2002 Gesichtspunkte für zukünftige Revisionen des OPS-301:

unter 2.4 a) Gesichtspunkte der Relevanz:
Fachlich unverzichtbar
Fachlich etabliert
Wissenschaftlich evaluiert
Angaben zum Evidenzgrad zitierter Studien
Angaben zu anderen internationalen Prozedurenklassifikationen

unter 4. Prüfung vorhandener OPS-301 Codes:
Bestehende OPS-301 Schlüsselnummern werden unter den Gesichtspunkten 1. bis 3. überprüft.
Diese Gesichtspunkte müssen als Entscheidungshilfe für die Bearbeitung des OPS-301 von BMGS und DIMDI miteinbezogen werden.

Eine Einteilung nach Evidence-Based Medicine (EbM)-Kriterien von Studien/Veröffentlichungen ermöglicht Aussagen über die wissenschaftliche Evaluierung und über den Evidenzgrad.

Nach ÄZQ (Ärztliche Zentralstelle für Qualitätssicherung) und SIGN (Scottish Intercollegiate Guidelines Network) gelten nachfolgende Level im Sinne der Evidence-Based Medicine (EbM):

Level I: Im Sinne der ‘Evidence-Based Medicine’ gibt es ausreichende Nachweise für die Wirksamkeit aus systematischen Überblicksarbeiten (Meta-Analysen) über zahlreiche randomisiert-kontrollierte Studien.
Level II: Es gibt Nachweise für die Wirksamkeit aus zumindest einer randomisierten, kontrollierten Studie.
Level III: Es gibt Nachweise für die Wirksamkeit aus methodisch gut konzipierten Studien, ohne randomisierte Gruppenzuweisung.
Level IVa: Es gibt Nachweis für die Wirksamkeit aus klinischen Berichten.
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Kunsttherapeutische Forschung bei Krebspatienten
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Studien 14
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Abgeschlossene internationale Studien
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Dissertationen noch nicht abgeschlossen
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Veröffentlichungen/Studien zu Depression, Ängste etc. während der Erholungsphase
Veröffentlichungen/Studien zu Verzweiflung/Traumatisierung bei einem event. Auftreten eines Rezidives bzw. Metastasen - Begleitung während der terminalen und palliativen Phase
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Künstlerische Therapien in der Akutmedizin/Onkologie


Dies zu evaluieren wurde in der Geschichte der Künstlerischen Therapien dokumentiert.

Forschung in Kunst- und Musiktherapie und in anderen Künstlerischen Therapien

Zu Beginn des zweiten Weltkrieges 1939 lagen bereits 150 wissenschaftliche Studien zum Thema Kunsttherapie vor; 1965 waren es bereits 7000 (Gannt & Srauß-Schmal 1974).


Im deutschen Sprachraum beschäftigen sich unterschiedliche Berufsverbände und Gesellschaften seit vielen Jahrzehnten mit Forschung:

- Internationale Gesellschaft für Kunst Gestaltung und Therapie (IGKGT/IAACT)
- Berufsverband für Kunst-, Musik- und Tanztherapie - Europäischer Dachverband für künstlerische Therapien gem. e.V., First European Association of Arts Therapies (BKMT/FEAT)
• Berufsverband für Anthroposophische Kunsttherapie (BVAKT)
• Deutscher Fachverband für Kunst- und Gestaltungstherapie e.V. (DFKGT)
• Deutscher Arbeitskreis Gestaltungstherapie und klinische Kunsttherapie e.V. (DAGTP)
• Deutsche Gesellschaft für künstlerische Therapieformen und Therapie mit kreativen Mitteln (DGKT)
• Deutsche Gesellschaft für Musiktherapie e.V. (DGMT)
• Berufsverband der Musiktherapeutinnen und Musiktherapeuten in Deutschland e.V. (BVM)
• Deutsche Musiktherapeutische Vereinigung Ost e.V. (DMVO)
• Verein zur Förderung der Nordoff/Robbins Musiktherapie e.V.
• Arbeitsgemeinschaft der staatlich anerkannten Musiktherapieausbildungen (AMA)
• Ständige Ausbildungsleiterkonferenz privatrechtlicher musiktherapeutischer Ausbildungen (SAMT)
• Berufsverband für Heileurythmie (BVHE)
• Berufsverband tiefenpsychologisch ausgerichteter Tanztherapeut/innen (BTAT)
• Berufsverband der Tanztherapeut/innen (BTD)

Regelmässige Veröffentlichungen erscheinen im deutschen Sprachraum u.a. in den Zeitschriften:
• "Kunst & Therapie" (Richter Verlag, Köln)
• "Musik-, Tanz-, und Kunsttherapie" (Hogrefe, Göttingen),
• "forum" (Schweiz)

Massgebliche Veröffentlichungen zu Forschungsfragestellungen in Musiktherapie wurden von D. Aldridge unter "Kairos" (1-5) (1997-2001); "Musiktherapie in der Medizin" (1999) bei Huber, Bern; herausgegeben.


Darüber hinaus werden an verschiedenen Lehrstühlen unterschiedlicher Fachbereiche Forschungsarbeiten/Promotionen zu dem Thema Kunsttherapie/Musiktherapie in der Medizin/Heilpädagogik durchgeführt. U.a.:

Weiter bemühen sich Dr. Karin Dannecker (Berlin), Prof. Dr. Karl-Heinz Menzen (Katholische Fachhochschule Freiburg, Fachbereich Heilpädagogik), Prof. Dr. Dr. Dr. Hilarion Petzold (Europäische Akademie für psychosoziale Gesundheit), Prof. Dr. Gertraud Schottenloher (Akademie der freien Künste München), u.a. um Forschungsvorhaben.

Der validierte Wirksamkeitsnachweis von Prof. Dr. Dagmar Gustorff zu Musiktherapie mit Komapatient/innen zeigt, dass auf Intensivstationen die Musiktherapie Anwendung findet


**Psychoonkologie**


Trotz zunehmender Verbesserung der therapeutischen Möglichkeiten im Bereich der Chirurgie, der Radiologie und der internistischen Onkologie und somit verbesserter Heilungschancen, oder aber der Verlängerung der Lebenszeit, haben gerade diese neuen therapeutischen Optionen auch einen nicht zu vernachlässigenden belastenden Einfluss beispielsweise auf die Lebensqualität der Patienten. Die Psyche des an Krebs erkrankten Menschen wird somit nicht nur durch die Erkrankung, sondern nicht selten auch durch die Behandlung selbst stark beeinflusst. Auf der Basis diesen Wissens beschäftigt
sich die Psychoonkologie mit der Diagnostik und Behandlung verschiedener Störungen wie:

- "Ängste bezüglich der Behandlung der Erkrankung und deren Nebenwirkungen";
- "Depression, Ängste, Verzweiflung, Trauer/Wut, Hoffnungslosigkeit, Kontrollverlust, Hilf- und Hoffnungslosigkeit, zuweilen Suizidalität während der Erholungsphase";
- "Verzweiflung und Traumatisierung bei einem eventuellen Auftreten eines Rezidives bzw. Metastasen;
- "Begleitung während der terminalen und palliativen Phasen"

Somit übernimmt die Psychoonkologie während dieser verschiedenen Phasen der Erkrankung wesentliche Aufgaben, um den erkrankten Menschen bei der Bewältigung und dem Verlauf der Erkrankung zu unterstützen.

Als unterstützende Interventionen die nachweislich das emotionale Befinden von Patientinnen beispielsweise mit Brustkrebs verbessern werden folgende Massnahmen gesehen:
Interventionen laut Mamma Ca Leitlinie / Australien 1999 / (Tschuschke 2002)

Professionell geleitete Gruppen

→ Bewirkt Einfühlung und Teilung von Erlebnissen zwischen Patientinnen

Familientherapie

→ Erleichtert verbesserte Kommunikation, Zusammenhalt und Konfliktlösung, innerhalb des Familiensystems

Paartherapie

→ Ziel - Probleme und Aspekte in der Paarbeziehung

Ergänzende Therapien

→ Ergänzende Therapien können Kunsttherapie einschließen (Musiktherapie, Malen, Lesen, Dichten)

Selbsthilfegruppen und Peerunterstützung

→ Unterstützende Gruppen mit Frauen

Telefonberatung

→ Ermöglicht geografisch isolierten Patientinnen die Möglichkeit für kognitiv behaviorale oder supportive Psychotherapie-Interventionen

Literatur:


5. Deutsche Arbeitsgemeinschaft für Psychosoziale Onkologie (dapo) e.V. Leitlinien für psychosoziale Betreuung von Brustkrebsbetroffenen. www.dapo-ev.de/leitl.html


8. Leitlinien-Programm für psychosoziales (psychoonkologisches) Disease Management bei Brustkrebs-Erkrankungen Univ.-Prof. Dr. Dipl.-Psych. Volker Tschuschke, Lehrstuhl für Medizinische Psychologie am Universitätsklinikum Köln, Mai 2002

Kunsttherapeutische Forschung bei Krebspatienten

Im Laufe ihrer langjährigen Zusammenarbeit mit dem Psychoonkologen Fritz Meerwein stellte auch die Psychoanalytikerin Esther Dreifuss-Kattan schon 1990 fest, welch großen Einfluss - neben den unmittelbaren körperlichen Beeinträchtigungen und Schmerzen- die psychischen Aspekte einer Krebserkrankung, die mit dem Leiden und seiner Behandlung verbundenen Gefühle auf die Lebensqualität des Patienten nehmen können.


Dreifuss-Kattan erklärt die heilsame Wirkung der Kunst an einer Stelle wie folgt: "Literarische oder künstlerische Arbeit ermöglicht es dem Krebspatienten, die Gegebenheiten der Krankheit von den daran beitragenden Gefühlen bis zu den
Einzelheiten der Behandlung zu objektivieren, zu externalisieren und damit zu kommunizieren. Gegebenheiten, die von Angesicht zu Angesicht nur schwer mitteilbar sind" (Dreifuss-Kattan 1993 S.16)

Das erweiterte Ausdrucksvermögen, der kommunikative Aspekt der Kunst, erlaubt dem Patienten jedoch nicht nur, sich von unsäglichen, belastenden Gefühlen zu distanzieren, indem er sie externalisiert; es befähigt ihn auch, sich Gefühle und Erfahrungen wieder anzueignen, die er im Verlauf oder schon vor Ausbruch der Krankheit aus seinem Bewusstsein verbannt hatte. Über die künstlerische Gestaltung erfährt er, dass er trotz seiner Krankheit im Kontakt mit seiner Umwelt ist, aufnehmen und erleben kann. Dieses Wechselspiel von Externalisierung und Interanalisierung, die Reorganisation des Selbst, ist ein wesentlicher Zug des kunsttherapeutischen Wirkprozesses.

Weiterführende Untersuchungen zu Künstlerischen Therapien bei Tumorpatienten


In den nachfolgend genannten nationalen und internationalen Studien, deren abstracts, sowie den beispielhaft erwähnten weiteren Veröffentlichungen/Studien kann nur ein weites Feld geöffnet werden, welches keinen Anspruch auf Vollständigkeit erhebt, sondern nur den Blick schärft für qualitative und quantitative Forschung und zukünftige Qualitätssicherung der Künstlerischen Therapien in der Akutmedizin und Onkologie.
ABGESCHLOSSENE NATIONALE STUDIEN LIEGEN VOR

1. MELODIEENTWICKLUNG BEI BRUSTKREBS-PATIENTINNEN
Aldridge; Gudrun; Witten-Herdecke;

2. KUNSTTHERAPIE ALS SUPPORTIVE INTERVENTION BEI KREBS-PATIENTEN IM AKUTKRANKENHAUS (KONTROLLIERTE PILOTSTUDIE)
Grulke, Norbert; Bailer, Harald; Stähle, Stefanie, Juchems, Alexandra; Heitz, Vera, Herrlen-Pelzer, Sybille, Blaul, Karin; Hirlinger, Brigitte; Kächele, Horst
Abteilung Psychotherapie und Psychosomatische Medizin, Universitätsklinikum Ulm
Wiesbaden, September 2002
Einordnung nach EBM erfüllt auf jeden Fall den Level 3 der Wirksamkeitsnachweise. Dadurch, dass die Kontrollgruppe randomisiert zusammengestellt ist, enthält sie Qualitätselemente von Level 2. Zu einer Einordnung nach Level 2 fehlt lediglich die Zusammensetzung der Therapiegruppe nach dem Zufallssprinzip.)

3. EVALUATION VON MAL- THERAPIE MIT KREBS-PATIENTEN (PILOTSTUDIE)
Herrlen-Pelzer, Sibylle, Rechenberg, Petra
Mit Aubele U, Frasch H, Goldgräbe Ch, Haidt J, Hoffmann K, Goeman K, Lenz G, Posch C, Porzsolt F, Roller S, Schneider Ch und Heimpel H
Medizinischen Universitätsklinikum Ulm 1998
Die Studie erfüllt die Anforderung nach EBM Level 4b. Es findet eine systematische qualitative Bildauswertung nach zuvor entwickelten Kriterien durch ein Expertenkomitee statt. In dieser Einzelfallstudie wird der qualitative Veränderungsprozess anhand der Bilder nachvollziehbar gemacht.

4. MUSIKTHERAPIE WÄHREND DER CHEMOTHERAPIE
Weber, Susan; München, Großhadern;

5. ADJUVANTE PSYCHOSOZIALE BEHANDLUNGSANGEBOTE IN DER KNOCHENMARKSTRANSPLANTATION (KMT)
gefördert von der Deutschen Forschungsgemeinschaft DFG (Förderkennzeichen: Za 170/2-1.2-2,2-3)
Antragsteller: Prof.Dr.med. A.R. Zander, Einrichtung für Knochenmarktransplantation, Universitätskrankenhaus Hamburg Eppendorf;
Antragsteller und Projektleitung: Prof. Dr. phil. M. Hasenbring, Abt. Medizinische Psychologie, Medizinische Fakultät, Ruhr-Universität Bochum; Klinische Leitung/ stellv. Projektleiter: Dr. F. Schulz-Kindermann, Dipl.-Psychologe;
ProjektmitarbeiterInnen: Ute Hennings, Musiktherapeutin; Dieter Linhart, Dipl.-Psychologe;
Gesa Ramm, Dipl.-Psychologin; Manuel Florian, Dipl.-Psychologe;

Eine Randomisierte Kontrollgruppenstudien A (Evidenz-Grade Ia, Ib) ist belegt durch Enthaltung mindestens einer randomisierten, kontrollierten Studie. Dies betrifft nur Evidenz von PMR/GI.

Belastungsformen; incl. Belastungsgruppen (z.B. nach ICD-10; gemäß psychometrischer Verfahren): Epidemiologische Studien, qualitative Studie

6. MUSIC AND ANESTHESIA IN PAIN THERAPY

Spintge, R.
Anesthesiologie, Intensivmedizin, Notfallmedizin, Schmerztherapie. 35(4):254-61, 2000

Qualitative Studie

ABGESCHLOSSENE STUDIEN LIEGEN VOR

7. ART THERAPY WITH ADULT BONE MARROW TRANSPLANT PATIENTS IN ISOLATION: A PILOT STUDY

Bonnie, Gabriel, Bromberg, Elissa, Vandenbovenkamp, Jackie, Walker, Patricia, Kornbith, Alice B., Luzatto, Paola (2001)
Memorial Sloan-Kettering Cancer Center, New York, NY, USA; John Wiley & Sons, Ltd., Psycho-Oncology 10: 114-123

8. CREATIVE ART EXPRESSION FROM A LEUKEMIC CHILD

Cotton, M.A.
Art Therapy 2:55, 1985

9. ART THERAPY AS SUPPORT FOR CHILDREN WITH LEUKEMIA DURING PAINFUL PROCEDURES

Favara-Scacco, Cinzia; Schiliro, Guiseppina and Di Cataldo, Andreas (2001)
Pilot study, Centro di Riferimento, Regionale di Ematologia ed Oncologia Pediatrica, University of Catania, Italya; 2001 Wiley-Liss, Inc; Medical and Pediatric Oncology 36:474-480

10. THE IMPACT OF AN ART PROGRAM ON AN INPATIENT ONCOLOGY UNIT

Ferszt, Ginette G., U Rhode Island, Graduate Program in Psychiatric-Mental Health Nursing, Kingston, RI, US
Massotti, Elaine, Williams, Jane, Miller, Jean R.
11. HOW THE ART FOR RECOVERY PROGRAM AFFECTS BREAST CANCER PATIENTS

Moynihan, Joan Irene, California Inst Integral Studies,
US Source: Dissertation Abstracts International: Section B:
Publisher: US: Univ Microfilms International.

12. DER EINFLUSS DER MAL- UND GESTALTUNGSTHERAPIE AUF DIE KRANKHEITSBEWÄLTIGUNG VON KREBS-PATIENTEN – EINE PILOTSTUDIE

Müller, Karin, Vogt Fux, Barbara, Maislinger, Susanne; Lukas, Peter; Söllner, Wolfgang
Univ. Klinik für Medizinische Psychologie und Psychotherapie, Univ. Klinik für Strahlentherapie und Radioonkologie Innsbruck.

13. ANNE: AM ILLUSTRATIVE CASE OF ART THERAPY WITH A TERMINALLY ILL PATIENT

Kern-Pilch, K.
Am J Art Ther; 70(1), 1982
pp.:3-11

14. AN ILLUSTRATED STUDY OF A YOUNG MAN WITH CANCER

Rudolff, Michael

15. THE INFLUENCE OF PERSONAL MESSAGE WITH MUSIC ON ANXIETY AND SIDE EFFECTS ASSOCIATED WITH CHEMOTHERAPY

Cancer Nursing, Aug; 1996; 19 (4): 283-289

16. KUNSTTHERAPIE IN DER ONKOLOGIE

Literaturstudie
Jacabos, Christina, 2000 (Medizinische Hochschule Hannover)
17. ERFAHRUNGEN VON BRUSTKREBS-PATIENTINNEN MIT DEM DIFFERENZIERTEN THERAPIEANGEBOT DES GEMEINSCHAFTSKRANKENHAUSES HERDECKE UNTER BESONDERER BERÜCKSICHTIGUNG KOMPLEMENTÄRER THERAPIEFORMEN _ RESTROSPEKTIVE FRAGEBOGENERHEBUNG BEI BRUSTKREBS-PATIENTINNEN 1995/1996
von Rauer, Kornelia 2000 (Medizinische Hochschule Hannover)

ABGESCHLOSSENE HABILITATIONEN LIEGEN VOR
18. KUNST- UND KULTURANALYSE IN DER ÄSTHETISCHEN UND THERAPEUTISCHEN PRAXIS
Hampe; Ruth, Dr. Phil
Als schriftliche Habilitationsleistung ausgewählte Arbeiten in drei Bänden dem Fachbereich 12 der Universität Bremen vorgelegt; Angestrebtes Lehr- und Forschungsgebiet: Pädagogik mit dem Schwerpunkt ästhetische Praxis und Kulturpsychologie

LAUFENDE NATIONALE STUDIEN ONKOLOGIE
19. KUNSTTHERAPIE UND KRANKHEITSVERARBEITUNG BEI KREBS
Vollmer, Dr. T., Kohls, D., Staroszynski, Th., Hiddemann, Prof. Dr. W.
Ein Forschungsprojekt der Medizinischen Klinik und Poliklinik III des Klinikums der Ludwig-Maximilian-Universität München-Großhadern 2002
Direktor Prof. Dr. med. Wolfgang Hiddemann

LAUFENDE NATIONALE STUDIEN AKUTMEDIZIN/GYNÄKOLOGIE
20. KUNSTTHERAPEUTISCHE BEGLEITUNG BEI VORZEITIGER WEHENTÄTIGKEIT
Faißt-Bischofberger, Ulrike; Menzen, Prof. Dr. K.-H. (Betreung), Internationale Hochschule für künstlerische Therapien und Kreativpädagogik, Calw,
Institut für Medizinische Psychologie Münster, Muthny, Prof. Dr. F.

LAUFENDE INTERNATIONALE STUDIEN
21. KUNSTTHERAPIE BEI KORONARKRANKEN UND HYPERTONIEPATIENTEN
Wiener Hanuschkrankenhauses seit 2000 eine Prästudie. und seit 2002 Poststudie
OA Dr.G.Titscher, C.Niederreiter, Mag.C.Schöppl, Mag.K.Rothschild
DISSERTATIONEN (NOCH NICHT ABGESCHLOSSEN)

22. ENTWICKLUNG EINES HEILPÄDAGOGISCH
KUNSTTHERAPEUTISCHEN ANSATZES FÜR EINE STATIONÄRE
BEHANDLUNG KARDIOLOGISCH ERKRANKTER KINDER
(voraussichtlicher Abschluss 2003)
Mathar, Mirjam
Universität Köln, Seminar für Musische Erziehung in der Heilpädagogik,
Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B.Wichelhaus

23. ZEICHNERISCHE DIAGNOSTIK BEI PATIENTEN MIT CEREBRALEM
INSULT DER ARTERIA CEREBRI MEDIA
(voraussichtlicher Abschluss 2003)
Wenige, Isabell
Universität zu Köln, Seminar für Musische Erziehung in der Heilpädagogik,
Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B.Wichelhaus

24. UNTERSUCHUNG DER BEDEUTUNG DER REGRESSION BEI
ONKOLOGISCHEN ERKRANKUNGEN IM KINDES- UND JUGENDALTER
AUS KREATIVITÄTSTHEORETISCHER UND KUNSTTHERAPEUTISCHER
SICHT
(voraussichtlicher Abschluss 2003)
Wolski, Mike
Universität zu Köln, Seminar für Musische Erziehung in der Heilpädagogik,
Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B.Wichelhaus

WEITERE STUDIEN / LITERATUR

25. MUSIKTHERAPIE IN DER ONKOLOGIE; KONZEPTE UND STAND DER
FORSCHUNG
Rose, Jens-Peter; Naar, Kerstin; Weis, Joachim

26. DER BEITRAG DER PÄDAGOGISCHEN KUNSTTHERAPIE ZUR
REHABILITATIVEN; KOMPENSATORISCHEN UND PRÄVENTIVEN
INTERVENTION BEI HERZKRANKEN KINDERN UND JUGENDLICHEN
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Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung
in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch
Prof. Dr. B.Wichelhaus
27. KUNSTPÄDAGOGIK_KUNSTTHERAPIE: KORRELLIERENDE MÖGLICHKEITEN DER KRISENINTERVENTION BEI KREBSKRANKEN KINDERN UND JUGENDLICHEN

Heitkamp, Anja (1991)
_Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B. Wichelhaus_

28. MUSIKUNTERSTÜTZTE KUNSTTHERAPIE ALS INTERVENTION IN DER REHABILITATION VON PATIENTEN NACH SCHLAGANFALL

Körbel, Vera (1999)
_Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B. Wichelhaus_

29. MÖGLICHKEITEN UND GRENZEN DER KUNSTTHERAPEUTISCHEN INTERVENTION IM BEREICH DER HÄMATOLOGISCH-ONKOLOGISCHEN PÄDIATRIE

Lux, Karen (1996)
_Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B. Wichelhaus_

30. KUNSTTHERAPIE MIT PATIENTEN EINER NEUROLOGISCHEN TAGESKLINIK NACH SCHLAGANFALL IN DER MITTLEREN LEBENSPHASE

Zielbauer, Sisko (1999)
_Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B. Wichelhaus_

31. BILDNERISCHE MÄRCHENGESTALTUNG BEI KINDERN MIT PSYCHOSOZIALER BELASTUNG

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_Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B. Wichelhaus_

32. EINE PILOTSTUDIE ZUR KUNSTTHERAPIE AN DER FRAUENKLINIK ST.-JÜRGEN-STR. IN BREMEN

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aus: Musiktherapie in der Onkologie
Musiktherapeutischen Umschau, Heft 4, Band 20 (1999),
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Abstracts

2. Grulke, Norbert; Bailer, Harald; Stähle, Sabine; Juchems, Alexandra; Heitz, Vera; Herrlen-Pelzer, Sibylle; Blaul, Karin; Hirlinger, Brigitte; Kächele, Horst

Abteilung Psychotherapie und Psychosomatische Medizin, Universitätsklinikum Ulm

Wiesbaden, September 2002

KUNSTTHERAPIE ALS SUPPORTIVE INTERVENTION BEI KREBSPATIENTEN IM AKUTKRANKENHAUS (KONTROLLIERTE PILOTSTUDIE)

Die Patienten der hämatologisch-onkologischen Stationen der Uni-Klinik Ulm haben die Möglichkeit, zweimal wöchentlich an einer kunsttherapeutischen Gruppe teilzunehmen.


Methode:

- Prospektive, kontrollierte Studie mit zwei Messzeitpunkten:
- Erste Einschätzung nachdem der Patient die Kunsttherapie begonnen hat.
- Zweite Einschätzung ca. drei Monate später.

Die Patienten der Kontrollgruppe erhielten die Fragebögen zu denselben Messzeitpunkten.

Instrumente / Fragebögen:

- Semi-strukturiertes Interview
- Profile of Mood States (POMS; Ge-stimmtheit): 4 Skalen
- Hospital Anxiety and Depression Scale (HADS; Angst, Depression): 2 Skalen
- Mental Adjustment to Cancer Scale (MAC-Scale; Krankheitsbewältigung): 5 Skalen
- Lebensqualität: EORTC QLQ-C30: 15 Skalen

Ergebnisse:

Zum ersten Messzeitpunkt stehen die Daten von 21 Patienten der Interventionsgruppe (IG) und von 24 Patienten der Kontrollgruppe (KG), zum zweiten
Messzeitpunkt die Daten von 16 (IG) und 15 Patienten (KG) zur Verfügung (IG: 3 Patienten verstorben, 2 Patienten waren nach Entlassung nicht mehr verfügbar; KG: 2 Patienten verstorben, 2 Patienten konnten wegen somatischer Beschwerden die Fragebögen nicht ausfüllen, 5 Patienten ohne Motivation zur weiteren Teilnahme).

Verglichen mit der Kontrollgruppe zeigten IG-Patienten eine Verbesserung auf allen 26 Skalen (z.B. bessere Stimmung, ge-ringere Sorge und Depression, bessere Krankheitsbewältigung und gesteigerte Lebensqualität), davon 12 signifikant. Im Gegensatz dazu weisen die Patienten der Kontrollgruppe keine Unterschiede zwischen den Messzeitpunkten t1 und t2 auf bzw. haben sich verschlechtert.

Diskussion:
Das Angebot der Kunsttherapie in einem Akutkrankenhaus (Universitätsklinik) wird nur von wenigen Patienten (und Kollegen) angenommen. Für dieses Klientel scheint sie jedoch eine sehr hilfreiche und wirkungsvolle Intervention zu sein.


Obwohl die Interventionsgruppe sich der Studie selbst zuteilte und sich in einigen sozio-demographischen Variablen von der Kontrollgruppe (n.s.) unterschied (IG-Patienten waren tendenziell jünger, besser gebildet und weiblich), denken wir, dass weitere Forschung (Wirkfaktoren, differentielle Indikation) im Feld der Kunsttherapie fruchtbar sein wird.

Zusammenfassung:

• Patienten, die an einer Kunsttherapie teilnehmen, profitieren davon.
• Der Effekt der Kunsttherapie kann mit Standardinstrumenten gemessen werden.

Veröffentlichungen


GRULKE, N., BAILER, H., STAEHLE, S., HERRLEN-PELZER, S., BLAUL, K., HIRLINGER, B. & KAECHELE, H. (2001b). Psychological effect of art therapy on haematological-oncological patients - a pilot study with a control group design (abstract # P161). In: Khayat, D. & Hortobagyi (Eds.), Book of

3. Herrlen-Pelzer, Sibylle und Petra Rechenberg
Medizinischen Universitätsklinik Ulm 1998

EVALUATION VON MALTHERAPIE MIT KREBSPATIENTEN (PILOTSTUDIE)


Unsere erste Maltherapeutin, Christa Schneider, kam spontan zum AK, um - bei einem eigenen Tumorverdacht - unbedingt mit Krebspatient/innen zu arbeiten und hat mit großem Engagement die Maltherapie auf den hämatologisch-onkologischen Stationen eingerichtet. Die Finanzierung gelang zunächst dadurch, dass vom Einzug übrig gebliebene Mittel zu Personal-Aufwendungen umgewidmet wurden, hier in Form von Werkverträgen. Der Beginn der Maltherapie war schwierig, mühsam und brachte viel Ärger, es fehlte an Raum und Akzeptanz auf allen Ebenen.


Bei der Maltherapeutin Christa Schneider stellte sich nach dem Abschluss der Studie tatsächlich der befürchtete Tumor heraus, an dem sie 1998 verstorben ist! Es ist ihr Verdienst und Vermächtnis, dass die Maltherapie - weiterhin 2x wöchentlich - fortgesetzt wird; das Klinikum finanziert sie in Form von Werkverträgen.


Die Erstbilder aus dieser Studie zeigen in den Motiven, Farben, wie in der Dynamik übereinstimmende Merkmale. Sie erscheinen konfliktträchtig, chaotisch, ausufernd oder explosiv. Die Verunsicherung durch die Krankheit mit besonderen Ängsten und Belastungen stellt sich deutlich dar, was der Unsicherheit im meist ungewohnten Malen zu entsprechen scheint.

Bei den Folgebildern wird nach Lösungen gesucht. Motive und Farbspiele werden weitergeführt, dabei tauchen kreative neue Figuren, Wege, Stege, Brücken, oder gar ein phantasievoller Regenbogen auf.

5. Zander, A.R., Prof.Dr.med.

ADJUVANTE PSYCHOSESIALE BEHANDLUNGSANGEBOTE IN DER KNOCHENMARKSTRANSPLANTATION (KMT)

gefördert von der Deutschen Forschungsgemeinschaft DFG
(Förderkennzeichen: Za 170/2-1.2-2,2-3)

Im Rahmen einer von der DFG geförderten randomisierten experimentellen Therapiestudie sollten Möglichkeiten der optimalen psychologischen Vorbereitung und Begleitung von PatientInnen des hämatopoetischen Systems (Leukämie, Morbus Hodgkin, Non-Hodgkin-Lymphom) entwickelt werden, die sich einer Knochenmarktransplantation unterziehen. In dem in der Hamburger Einrichtung für Knochenmarktransplantation des Universitätskrankenhauses stattfindende Vorhaben sollten die spezifischen Interventionseffekte untersucht werden, d.h., es wurde geprüft, inwieweit zwei spezifische Interventionsangebote (Progressive Muskelrelaxation und Geleitete Imagination (PMR/GI) und Musiktherapie (MT)) effektiver sind als ein eher unspezifisches Geprächsangebot (NG). Dabei wurde das Verfahren Musiktherapie erstmals in diesem Setting und im Rahmen einer randomisierten Kontrollstudie empirisch überprüft. Die psychologischen Maßnahmen zielten im einzelnen auf:

1. Abbau von Gefühlen der Angst und Depressivität
2. Verringerung der Belastung durch primär behandlungsbedingte körperliche Beschwerden wie Übelkeit, Erbrechen und Schmerzen
3. kurzfristige Konfliktlösung sekundärer Belastungen im beruflichen und privaten Alltag
4. Erweiterung des individuellen Repertoires an günstigen Krankheitsbewältigungsformen
5. Förderung von Gefühlen der Sebstwirksamkeit und Selbstkontrolle.

Es wurden Hypothesen zur differentiellen Wirksamkeit der einzelnen Verfahren formuliert. Über den klinisch-angewandten Aspekt hinaus verfolgte das Projekt einen Beitrag zur Klärung der grundlagentheoretischen Fragestellung, ob über verschiedenen psychologische Interventionen in diesem Bereich differenziierbare Effekte oder lediglich eine gemeinsame, unspezifische Wirkung erzielt werden kann.

Mit Beginn der Auswertung der Studie lagen vollständig, d.h. inklusive Ein-Jahreskatamnese, N=63 PatientInnen vor, 41 der PatientInnen waren männlich und 22 weiblich. Das Durchschnittsalter betrug 40,2 Jahre.

Ergebnisse

Im Vergleich PMR/GI und MT kann man den Schluss ziehen, dass PMR/GI eher unmittelbar die somatischen Beschwerden positiv beeinflusst, während das musiktherapeutische Angebot primär die emotionale Befindlichkeit förderte.

Eine Randomisierte Kontrollgruppenstudien A (Evidenz-Grade Ia, Ib) ist belegt durch Enthaltung mindestens einer randomisierten, kontrollierten Studie. Dies betrifft nur Evidenz von PMR/GI.

Belastungsformen; incl. Belastungsruppen (z.B. nach ICD-10; gemäß psychometrischer Verfahren): Epidemiologische Studien

Verfahren zur Bedarfsermittlung: Psychometrische Verfahren hinreichender Güte z.B. BDI, sonstige psychometrische Verfahren z.T. selbst entwickelte Verfahren (VAS)

Prozessindikatoren: z.B. Gesprächshäufigkeit und dauer, Kooperationsformen, Standardisierte Therapiedokumentation

Ergebnisindikatoren: Lebensqualität, Patientenzufriedenheit

Qualitätsindikatoren: Struktur (Qualifikation, Arbeitsstrukturen, Diagnostik, Intervention, Evaluation, Dokumentation, usw.); Prozeß (alles, was über Prozeßindikatoren erfaßt werden kann); Ergebnisse (alles was über die entsp. Indikatoren erfasst werden kann) Siehe Abschlußbericht des Forschungprojektes für die DFG

Veröffentlichungen:

F Schulz-Kindermann, U Hennings, G Ramm, AR Zander and M Hasenbring (2002). The role of biomedical and psychosocial factors for prediction of pain and distress in patients undergoing high.dose therapy and BMT/PBSCT. Bone Marrow Transplantation 29: 341-351


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Ramm G, Linhart D, Zander AR, Hasenbring M (1999). Positive and negative effects of social relationship on patients undergoing BMT or PBSCT. Bone Marrow Transplantation 23 (Suppl.1) 169

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Schulz-Kindermann F, Hennings U, Gerlach P, Zander AR (1999). Stages, problems and possibilities of social support in high-dose chemotherapy and BMT/PBSCT. Bone Marrow Transplantation 23 (Suppl.1) 258

8. Cotton, M.A.
Art Therapy 2:55, 1985
CREATIVE ART EXPRESSION FROM A LEUKEMIC CHILD
Discusses whether the healing process through art could alleviate the mental and physical traumas of leukemia in its acute and advanced stages and examines the power of art to reveal the progression of death awareness. A case study of a 6-yr-old girl with acute lymphoblastic leukemia is presented. Art therapy was conducted with the S for approximately 6 mo, after which she died. S’s drawings revealed a pattern in the use of color and page placement when she was not feeling well; correlations between S’s drawings and those described by C. F. Perkins (1977) in a study of the art of life-threatened children were observed. Red and black were evident in many pictures, as were paths leading toward the upper left quadrant of the page, which could indicate death. It is concluded that S’s experiences with art provided her with an interest, a mutual continuing relationship with the therapist, and an incentive to reveal her feelings.

10. Ferszt, Ginette G.,
U Rhode Island, Graduate Program in Psychiatric-Mental Health Nursing, Kingston, RI, US
THE IMPACT OF AN ART PROGRAM ON AN INPATIENT ONCOLOGY UNIT
Describes an exploratory qualitative research study that examined the potential benefits of an arts program on an inpatient oncology unit located in a major medical center in New England. Semistructured interviews of 7 patients (aged 21-83 yrs) and 7 nurses who cared for these patients were conducted following...
participation in an established arts program. Benefits included improved patient coping with pain, improved nurse-patient communication, and improved attitude toward hospitalization.

11. Moynihan, Joan Irene, California Inst Integral Studies, US Source: Dissertation Abstracts International: Section B:

HOW THE ART FOR RECOVERY PROGRAM AFFECTS BREAST CANCER PATIENTS

This is a phenomenological and a quantitative inquiry into the effects of Art For Recovery on three female breast cancer patients. The Attending Artist and the patients were interviewed separately following nine AFR sessions. Nine patient interviews were phenomenologically analyzed. Nine Attending Artist interviews were analyzed for their intentions. Each patient was given a Perception of Illness and Perception of Treatment Questionnaire before her initial AFR session and after her final AFR session. The qualitative and quantitative results were compared. This non-theoretical, basically co-creative and emotionally connecting process begins with the energetically bi-directional, creative, interactive relationship in which the patient may or may not artistically express what she is feeling. The mission of AFR is to assist the patient in developing her own creative spirit. The director of AFR, the Attending Artist in this study who developed the AFR process, bases her approach on being true to herself, whole, and listening deeply.

12. Müller, Karin; Vogt-Fux, Barbara; Maislinger, Susanne; Lukas, Peter; Söllner, Wolfgang

Univ. Klinik für Medizinische Psychologie und Psychotherapie, Univ. Klinik für Strahlentherapie und Radioonkologie Innsbruck.

DER EINFLUSS DER MAL_ UND GESTALTUNGSTHERAPIE AUF DIE KRANKHEITSBEWÄLTIGUNG VON KREBSPATIENTEN – EINE PILOTSTUDIE

In einer Pilotstudie wird der Frage nachgegangen, inwieweitsich die Teilnahme an einer Mal- und Gestaltungstherapie auf die Krankheitsbewältigung von Krebpatienten auswirkt. Der Schwerpunkt liegt darauf, ob sich während der Teilnahme Veränderungen abbilden lassen und wie die Patienten ihre Teilnahme an der Mal-und Gestaltungstherapie erleben.

Es wurden 12 radioonkologische Patienten mit unterschiedlichen Krebserkrankungen, die an der Malgruppe teilnahmen, zu vier Zeitpunkten untersucht (Beginn, Mitte, Ende der Teilnahme, 1-Jahres-Follow-up. Zur Erfassung der Wahrnehmung ihrer Teilnahme an der Mal-und Gestaltungstherapie wurde ein halbstrukturiertes Interview (Leitfadeninterview) durchgeführt. Mit diesem wurden Veränderungen der Lebens- und Krankheitssituation, spezifische Belastungen und Ressourcen, sowie die
Einstellung zu kreativen Therapieformen und die subjektive Sichtweise der Patienten zur Maltherapie erhoben. Zusätzlich beantworteten die Patienten Fragebögen zur Krankheitsverarbeitung (FKV-LIS, zu ihrem Stimmungszustand (POMS), zu Angst und Depression (HADS) und zu ihrer Wahrnehmung von sozialer Unterstützung (Social Support Scale).

Die Interviews wurden mit Hilfe der qualitativen Inhaltsanalyse (Methode nach Mayring) ausgewertet. Die Ergebnisse dieser Auswertung werden dargestellt und diskutiert.

Veröffentlichung in


13. Kern-Pilch, K.
American Journal of Art Therapy; 70(1), 1982

ANNE: AN ILLUSTRATIVE CASE OF ART THERAPY WITH A TERMINALLY ILL PATIENT

The role of art therapy in liaison psychiatry is illustrated by the case of a terminally ill elderly woman with lymphocytic leukemia. Art can serve as a self-enhancing outlet for energies that otherwise might be expressed in a negative manner. The patient maintained control, asserted herself, and made decisions through art. Art helped the patient to resolve her feelings and to accept impending death.

14. Rudolff, Michael

American Journal of Art Therapy (1985)

AN ILLUSTRATED STUDY OF A YOUNG MAN WITH CANCER

Describes art therapy with a 23-yr-old man dying of cancer who, as a result of his experiences of loss and rejection, never expressed his feelings directly. The release of the patient's suppressed feelings through art therapy is described and illustrated with examples of his drawings.

15. Sabo, C.E., Michael S.R.

Cancer Nursing, 1996

THE INFLUENCE OF PERSONAL MESSAGE WITH MUSIC ON ANXIETY AND SIDE EFFECTS ASSOCIATED WITH CHEMOTHERAPY

The purpose of this pilot study was to evaluate the benefits of a message from a patient's physician audiotaped over music on reducing anxiety and side effects of patients receiving chemotherapy. A convenience sample of 97 adult patients receiving chemotherapy for the first time was assigned to either an experimental
or control group. Before beginning the first chemotherapy treatment, all subjects completed a demographic questionnaire and the Spielberger State Anxiety Inventory (SSAI). Participants in the experimental group (n = 47) received taped music and a message from their physicians during the next four chemotherapy treatments. Participants in the control group (n = 50) received no intervention from the researchers and underwent their next four chemotherapy treatments as prescribed. After the fourth chemotherapy treatment, the SSAI and a side-effects self-assessment evaluation were completed by all subjects. A paired one-tailed t test found a significant difference between pre- and postintervention scores on the state anxiety scale (p < 0.001). In addition, anxiety remained the same over time in the control group. There was no significant difference in the severity of side effects experienced between control and experimental groups. These preliminary findings indicate that a simple and cost-effective intervention can decrease a patient's anxiety when receiving chemotherapy.

- Kontrollgruppe (nicht randomisiert)
- „B“ (Evidenz-Grade IIa, IIb, III) ist belegt durch nicht randomisierte, klinische Studien
- Psychometrische Verfahren hinreichender Güte (SSAI)
- Ergebnisindikatoren: Funktionalität
- Qualitätsindikatoren: Struktur (Intervention, Evaluation)
- Ergebnisse

16. von Christina Jacobos

Medizinische Hochschule Hannover (Betreuung Prof. em. Dr. med. Peter Petersen)

KUNSTTHERAPIE IN DER ONKOLOGIE

Literaturstudie 2000


17. Rauer, Kornelia

Medizinische Hochschule Hannover, 2000 (Betreuung Prof. em. Dr. med. Peter Petersen)
ERFAHRUNGEN VON BRUSTKREBS-PATIENTINNEN MIT DEM DIFFERENZIERTEN THERAPIEANGEBOT DES GEMEINSCHAFTSKRANKENHAUSES HERDECKE UNTER BESONDERER BERÜCKSICHTIGUNG KOMPLEMENTÄRER THERAPIEFORMEN _ RESTROSPEKTIVE FRAGEBogenerhebung bei Brustkrebspatientinnen 1995/1996

Ziel der Studie ist es, den Einfluß künstlerischer Therapien auf die Krankheitsverarbeitung zu untersuchen. Zur Erfassung setzt die Autorin in einer retrospektiven Befragung der nach Behandlung entlassenen Patientinnen neben einem selbst entwickelten, nicht normierten und auf Reliabilität untersuchten Fragebogen ergänzend standardisierte Instrumente eingesetzt wie FKV, BL, state anxiety inventory, HLQ, wobei die Autorin die Skalen so veränderte, dass in allen Fällen mindestens 4 Abstufungen vorlagen. Die standardisierten Fragebögen wurden nicht differenziert nach Art der durchgeführten komplementären Therapie erhoben.

Die Maltherapie betreffen insgesamt 11 Fragen zur Beurteilung der Maltherapie durch die Patientinnen und zur Krankheitsverarbeitung mit Hilfe der Maltherapie. Weiter dokumentiert die Autorin die vorliegenden zusätzlichen Klartextkommentare von 14 Patientinnen.

Im Ergebnis zeigt die Studie, dass das Gesamtkonzept der Behandlung mit den Komplementärtherapien die Krankheitsverarbeitung und damit die Rehabilitation fördert, wobei die Wirkung der künstlerischen Therapien von den Patientinnen positiv beurteilt wird.

Beurteilung nach EBM:


18. Hampe, Ruth, Dr.phil. Kunst- und Kulturanalyse in der ästhetischen und therapeutischen Praxis Habilitation
Angestrebtes Lehr- und Forschungsgebiet:
Pädagogik mit dem Schwerpunkt ästhetische Praxis und Kulturpsychologie

Veröffentlichungen:

Band II Kunsttherapie und kulturelle Praxisformen
XIV Ästhetisches Lernen und Therapie in einer Bremer Frauenklinik, in: "Hospital Art" - Kunst im Krankenhaus, Institut für Bildung und Kultur e.V. (Hrsg.), Bd. 13, Remscheid 1989, S. 136-144. 382
XV Zur kunsttherapeutischen Praxis im klinischen Bereich, in: Materialien zur Fachtagung "Hospital Art - Kunst im Krankenhaus", Institut für Bildung und Kultur e.V. (Hrsg.), Bd. 12, Remscheid 1988, S. 14-23. 390

Band III
Zur Frau und Geburt im Kulturvergleich
XXIV Mythen und Riten zur Geburt, in: Handbuch für Historische Anthropologie, 1996 i.D.

19. Vollmer, T. Dr.; Kohls, D.; Staroszynski, Th.; W. Hiddemann, W., Prof. Dr.
Ein Forschungsprojekt der Medizinischen Klinik und Poliklinik III des Klinikums der Ludwig-Maximilian-Universität München-Großhadern 2002
Direktor Prof. Dr. med. Wolfgang Hiddemann
KUNSTTHERAPIE UND KRANKHEITSVERARBEITUNG BEI KREBS


Thema der Studie ist die Etablierung von Kunsttherapie als zentraler Bestandteil des psychosozialen Begleitprogramms auf hämatologisch-onkologischen Stationen unter systematisch formativer Evaluation der Inanspruchnahme sowie der Wirkung auf die Krankheitsverarbeitung, Lebensqualität und spirituelle sowie allgemeine Befindlichkeit zur Verbesserung der Versorgung von krebskranken Menschen.

Kunsttherapie ist eine Therapieform, die verschiedene künstlerische Medien einsetzt.


Das Projekt untersucht in einer Pilotstudie die Wirkung kunsttherapeutischer Betreuung auf die Krankheitsverarbeitung und die Befindlichkeit von knochenmark- und stammzelltransplantierten PatientInnen. Des weiteren soll untersucht werden, welche persönlichkeitsbedingten und umweltbedingten Faktoren die Inanspruchnahme des kunsttherapeutischen Angebots bestimmen.


Nichtinanspruchnahme des kunsttherapeutischen Settings nach Information und Aufklärung über das kunsttherapeutische Angebot.

Bei der Konzeption der Studie war es von großer Bedeutung für die Projektleiter, ein anwendungsbezogenes Forschungsprojekt zu konzipieren, dass behandlungsbegleitend durchgeführt werden kann und keine

20. Faißt-Bischofberger, Ulrike; Menzen, Karl-Heinz

Internationale Hochschule für künstlerische Therapien und Kreativpädagogik, Calw,
Institut für Medizinische Psychologie Münster, F. Muthny

KUNSTTHERAPEUTISCHE BEGLEITUNG BEI VORZEITIGER WEHENTÄTIGKEIT


Die Bedeutung psychosozialer Aspekte der vorzeitigen Wehentätigkeit waren Anlass für mich, mein Praktikum auf der geburtshilflichen Abteilung des St. Elisabethen Krankenhauses in Lörrach zu absolvieren. Mit dem Ziel durch kunsttherapeutische Begleitung eine Stressreduktion zu erreichen, die Bewältigungskraft der Patientin zu stärken in der Hoffnung auf Einflußnahme der Schwangerschaftsdauer.

Die gewonnenen positiven Erfahrungen bestärkten mich das Thema, vorzeitige Wehentätigkeit, in einer Studie zu evaluieren.

In einer wissenschaftlichen retrospektiven Fragebogenuntersuchung (133 Items) "Zum Erleben der Schwangerschaft und Geburt und der Patientenzufriedenheit" habe ich versucht:

1. Belastungsfaktoren,
2. die Patientenzufriedenheit an Hand der eingeleiteten Klinikmaßnahmen,
3. und die Wirkung kunsttherapeutischer Begleitung aufzuzeigen.

Die Auswertung erfolgte am Institut für Medizinische Psychologie Münster (Prof. F. Muthny) das ich für eine Kooperation gewinnen konnte. Die Untersuchung der Gesamtstichprobe basiert auf der Datenanalyse von n = 70,
zusammengesetzt aus der Interventionsgruppe KT n = 23, und der Kontrollgruppe ohne KT n = 47.


21. Niederreiter C., Titscher G., Gaul G.
Kunsttherapie bei Koronarkranken und Hypertoniepatienten


Das Gruppenangebot gibt es getrennt nach Indikation für Koronarkranke oder HypertoniepatientInnen.

Die Gruppen werden mit jeweils 8 Personen als geschlossene Gruppe geführt.

Die Dauer beträgt 10 Einheiten zu jeweils 2,5 Stunden.

Die Frequenz ist 2x monatlich.


Aus den Erfahrungen dieser Prästudie haben wir das Setting beibehalten, setzen jedoch, um eine noch bessere Verknüpfung mit den entstandenen Bildern zu erhalten, teilweise andere Tests ein. Zusätzlich werden entsprechende Kontrollgruppen geführt, die keine Kunst- oder Psychotherapie bekommen.

Ergebnisse werden in ca. einem halben Jahr zur Verfügung stehen.

22. Mathar, Mirjam
Universität Köln, Seminar für Musische Erziehung in der Heilpädagogik, Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B. Wichelhaus

ENTWICKLUNG EINES HEILPÄDAGOGISCH KUNSTTHERAPEUTISCHEN ANSATZES FÜR EINE STATIONÄRE BEHANDLUNG KARDIOLOGISCH ERKRANKTER KINDER

(voraussichtlicher Abschluss 2003)


(voraussichtlicher Abschluss 2003)

Fördernde Institution: Kroschke Stiftung für Kinder, Verein der Freunde und Förderer des Herzzentrums der Universität zu Köln

Kinderkardiologie, Universitätskliniken Köln

Theoretische und empirische Studie (ausgearbeitetes Diagnose- und Evaluationsinstrument)

23. Wenige, Isabell

Universität zu Köln, Seminar für Musische Erziehung in der Heilpädagogik, Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B. Wichelhaus

ZEICHNERISCHE DIAGNOSTIK BEI PATIENTEN MIT CEREBRALEM INSULT DER ARTERIA CEREBRI MEDIA

(voraussichtlicher Abschluss 2003)

Im Rahmen der Studie werden Menschzeichnungen in divergierenden Abständen vom akuten Krankheitsereignis „cerebraler Insult“ mit qualitativen und quantitativen Methoden untersucht und formal und inhaltlich ausgewertet. Rehabilitative Prozesse allgemeiner und spezifischer Ausprägung sollen aufgezeigt werden.

In Zusammenarbeit mit dem Marienhospital/ Lünen (Dr. med. Gerlach) Empirische Studie zur Exploration des zeichnerischen Ausdrucksverhaltens (Mensch-Zeichnung) als Nachweis erfolgreicher neurologischer Rehabilitation mit kunsttherapeutischen Maßnahmen, korrelierend zu medizinischen Scors
24. Wolski, Mike
Universität zu Köln, Seminar für Musische Erziehung in der Heilpädagogik, Heilpäd. Kunsterziehung/Kunsttherapie, betreut durch Prof. Dr. B. Wichelhaus

UNTERSUCHUNG DER BEDEUTUNG DER REGRESSION BEI ONKOLOGISCHEN ERKRANKUNGEN IM KINDES_ UND JUGENDALTER AUS KREATIVITÄTSTHEORETISCHER UND KUNSTTHEREAPEUTISCHER SICHT
(voraussichtlicher Abschluss 2003)


Fördernde Institution: Elterninitiative krebskranker Kinder Sankt Augustin e.V.
Kinderonkologie, Johanniter-Kinderklinik in St. Augustin

Empirische Studie zur Überprüfung eines kunsttherapeutischen Modells in der Praxis mit onkologisch erkrankten Kindern, dargestellt anhand von ausgewählten Fallvignetten

25. Rose, Jens-Peter; Naar, Kerstin; Weis, Joachim

MUSIKTHERAPIER IN DER ONKOLOGIE; KONZEPTE UND STAND DER FORSCHUNG

Der vorliegende Artikel befasst sich mit den Einsatzmöglichkeiten und Wirkweisen der Musiktherapie (MT) bei erwachsenen KrebspatientInnen in der onkologischen Akutbehandlung sowie Rehabilitation. Er basiert auf einer Literaturstudie mit Blick auf den heutigen Stand der empirischen Forschung im onkologisch-musiktherapeutischen Sektor und der hieraus entstehenden Konsequenzen für Konzepte der Musiktherapie. Um die verschiedenen Forschungsansätze verständlich zu machen, werden eingangs die grundlegenden Aspekte des musiktherapeutischen Verfahrens erläutert und die speziellen Anforderungen durch das onkologische Klientel betrachtet. Im Weiteren werden Forschungsansätze der MT durch einschlägige deutsche Ausbildungsinstitute zusammen-fassend dargestellt. Die zu diesen Themen
gefundenen Studien und Kasuistiken werden in Form eines Reviews zusammengetragen, bewertet und liefern die Basis der abschließenden Forderungen an zukünftige musiktherapeutische Forschung, sowie Vorschläge für die musiktherapeutische Praxis in der Onkologie

26. Fauth, Nicole (1997)
Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, B. Wichelhaus

DER BEITRAG DER PÄDAGOGISCHEN KUNSTTHERAPIE ZUR REHABILITATIVEN; KOMPENSATORISCHEN UND PRÄVENTIVEN INTERVENTION BEI HERZKRANKEN KINDERN UND JUGENDLICHEN
Kunsttherapeutische Einzelfallstudie während und nach einem Krankenhausaufenthalt mit kardiologisch erkrankten Kindern (Langzeitstudie), unter Berücksichtigung familien-therapeutischer Aspekte

Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, B. Wichelhaus

KUNSTPÄDAGOGIK_KUNSTTHERAPIE: KORRELIERENDE MÖGLICHKEITEN DER KRISENINTERVENTION BEI KREBSKRANKEN KINDERN UND JUGENDLICHEN
Fallbeschreibung/Verlaufsdiagnosen anhand der Dokumentation von Bildsequenzen und Verhaltensbeobachtung (einschließlich Kommentierung)

Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, B. Wichelhaus

MUSIKUNTERSTÜTZTE KUNSTTHERAPIE ALS INTERVENTION IN DER REHABILITATION VON PATIENTEN NACH SCHLAGANFALL
Empirische Studien zur Wirksamkeit rehabilitativ orientierter, kunsttherapeutischer Programme in einem Rehabilitationszentrum (NTC Köln), Fallvignetten in der zweiten Phase der Rehabilitation nach Schlaganfall

Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, B. Wichelhaus
MÖGLICHKEITEN UND GRENZEN DER KUNSTTHERAPEUTISCHEN INTERVENTION IM BEREICH DER HÄMATOLOGISCH-ONKOLOGISCHEN PÄDIATRIE

Studie zur Lern- und Verhaltensänderung als Indikator für effektive kunsttherapeutische Maßnahmen mit Hilfe deutungsorientierter Verfahren, angewandt und dargestellt anhand von Bildsequenzen ausgewählter Fallbeispiele.

30. Zielbauer, Sisko

Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, B. Wichelhaus

KUNSTTHERAPIE MIT PATIENTEN EINER NEUROLOGISCHEN TAGESKLINIK NACH SCHLAGANFALL IN DER MITTLEREN LEBENSPHASE

Theoretische und empirische Studie unter Einbeziehung von Kontextvariablen zur Überprüfung der Reichweite (Wirksamkeit) kunsttherapeutischer Interventionen (Verlaufsbeobachtungen und Interview)


Diplomarbeit UNIVERSITÄT ZU KÖLN Seminar für Musische Erziehung in der Heilpädagogik; Heilpäd. Kunsterziehung/Kunsttherapie, B. Wichelhaus

BILDNERISCHE MÄRCHENGESTALTUNG BEI KINDERN MIT PSYCHOSOZIALER BELASTUNG

Studie zur Lern- und Verhaltensänderung als Indikator für effektive kunsttherapeutische Massnahmen mit Hilfe deutungsorientierter Verfahren, angewandt und dargestellt anhand von Bildsequenzen ausgewählter Fallbeispiele


Eine Pilotstudie zur Kunsttherapie an der Frauenklinik St.-Jürgen-Str. in Bremen

Das Projekt zur Integration kunsttherapeutischer Behandlungsformen an der Frauenklinik St.-Jürgen-Str. in Bremen unter dem damaligen Chefarzt Prof.Dr.Diether Langnickel wurde in der Zeit von 1987 bis 1988 durchgeführt und hatte die Schaffung von festen Stellen für zwei Kunsttherapeutinnen am ZKH St.-Jürgen-Str. zur Folge. Aufgrund der Durchführung einer Pilotstudie hat sich die Forschungsarbeit auf eine qualitative Erhebung zu kunsttherapeutischen Interventionen bei unterschiedlichen Krankheitsbildern -


Diese Ergebnisse sind den Publikationen zu entnehmen. Dies ist zudem in die Habilitationsschrift mit aufgenommen worden.

Wissenschaftliche Veröffentlichungen zum Pilotprojekt an der Frauenklinik
Zur kunsttherapeutischen Praxis im klinischen Bereich,
in: Materialien zur Fachtagung "Hospital Art - Kunst im Krankenhaus",
Institut für Bildung und Kultur e.V. (Hrsg.), Bd. 12, Remscheid 1988, S. 14-23.

Kunst und Therapie in einer Frauenklinik,
in: Bildung und Kultur. Dokumentation des Förderprogramms 1985-1988,
Institut für Bildung und Kultur e.V. (Hrsg.), Remscheid 1989, S. 60-61.

Ästhetisches Lernen und Therapie in einer Bremer Frauenklinik, in:
"Hospital Art" - Kunst im Krankenhaus,
Institut für Bildung und Kulture.V. (Hrsg.), Bd. 13, Remscheid 1989, S. 136-144.

Kunst und Therapie in einer Frauenklinik,
Institut für Bildung und Kultur e.V. (Hrsg.), Bd.14, Remscheid 1988 (83 Seiten).

Kunsttherapie als Krisenintervention,

Ästhetisches Lernen im klinischen Bereich,
in: Mitteilungsblatt der
Internationalen Gesellschaft für Kunst, Gestaltung und Therapie, Nr. 6, 1988.
Symbolisierung und Desymbolisierung in der kunsttherapeutischen Arbeit,
Zur kunsttherapeutischen Praxis im klinischen Bereich,

Hampe, Ruth / Wehkamp, Karl-Heinz:
Aurora II. Kunsttherapie und Neue Denkformen in der Frauenklinik,
in: W. Pöldinger (Hrsg.): Jahreskongreß der Deutschsprachigen Gesellschaft für Psychopathologie des Ausdrucks e.V.,

Sterben im Krankenhaus,
in: Die Pflege. Fachzeitschrift für stationäre und ambulante Pflege,
48. Jahrg., Heft 10, Okt. 1995,

Risk Pregnancy as a cultural phenomenon of modern society and possibility of art therapy,
in: Third European Arts Therapies Conference, conference proceedings,

Krisenintervention über ästhetische Erlebensformen in der Klinik,

Die Begegnung mit der eigenen Kreativität im Krankheitsfall,

Risikoschwangerschaft und sinnliche Erfahrungstätigkeit – eine kulturanalytische Studie,

Ästhetisches Gestalten als Krisenintervention in einer Frauenklinik,


"Kreative Bewältigungsformen von Angst und Streß". In: Schriftenreihe der Deutschen Gesellschaft für Gerontopsychiatrie und -psychotherapie, "

Nachwort

Diese Zusammenstellung von Studien/Veröffentlichungen über Künstlerische Therapien in der Akutmedizin und Onkologie kann ergänzt werden.

Deshalb wird freundlicherweise von Prof. Dr. David Aldridge eine Website unter www.musictherapyworld.net aufgebaut. Dort wird diese Arbeit für alle Interessierten zugänglich gemacht. Es können weitere Nennungen von Studien/Veröffentlichungen, abstracts, Einteilungen nach EbM-Kriterien eingereicht werden. Bitte senden an: studien@dfkgt.de

Somit können fehlende Angaben, die in der Kürze der Zeit nicht aufgenommen wurden, ergänzt werden. Ein Pool von Studien/Veröffentlichungen über Künstlerische Therapien in der Akutmedizin wird entstehen können.

Wir danken insbesondere dem Deutschen Fachverband für Kunst- und Gestaltungstherapie (DFKGT), der diese Arbeit ermöglichte, aber auch allen Kolleginnen und Kollegen, die Rückmeldungen über Studien an uns geschickt haben.

Prof. Dr. David Aldridge
Chair of Qualitative Research in Medicine
Alfred Herrhausen Str. 50.,
University Witten Herdecke
58448 WITTEN, Germany
website: http://www.musictherapyworld.net

Harald Gruber
Dipl. Kunsttherapeut (FH)
Klinik für Tumorbionologie
Braischerstrasse 117
79106 Freiburg

Bettina Kunzmann
Dipl. Kunsttherapeutin/pädagogin (FH)
Median Reha Zentrum
Kueser Plateau
54470 Bernkastel-Kues

Prof. Dr. phil. Joachim Weis
Tumor Biology Center
Department of Psychooncology
Braischer Str. 117
D-79106 Freiburg

Witten, Freiburg, Bernkastel-Kues, 23.10.2002
Music therapy and spirituality; A transcendental understanding of suffering

David Aldridge

Abstract

There has an emerging interest in spirituality in music therapy. This paper offers some definitions of spirituality and religion as sometimes the two terms are confounded. My position is that if spirituality is about the individual, ineffable and implicit; religion is about the social, spoken and explicit. Such definitions are an attempt to explicate the practices whereby spirituality is achieved. Spirituality lends meaning and purpose to our lives, these purposes help us transcend what we are.

The ability to rise above suffering, to go beyond the present situation to a realm where life takes on another, perhaps deeper, significance is an important factor in palliative care. Music therapy facilitates the process of connecting to that which is spiritually significant for the patient, thereby transforming experiences of suffering into those of meaning. This has been traditionally termed transcendence – to rise above the immediate situation, and is the basis of hope.
While we may strive for the eradication of major diseases, the presence of suffering will be a part of the human narrative. So too, then, the relief of that suffering. Through music, in the setting of music therapy, then we can promote relief. While the management of pain is often a scientific and technical task, the relief of suffering is an existential task. It can also be a musical task and therefore appropriate for music therapy.

There has indeed been an emerging interest in spirituality in the field of music therapy, particularly for those working in the ecology of palliative care (Aldridge 2000b; Aldridge 1995; Bailey 1997; Lowis and Hughes 1997; Magill 2002; Marr 1999; West 1994). In “Music therapy in palliative care: New voices” (Aldridge 1999), several authors reflect the need for spiritual considerations when working with the dying (Hartley 1999; Hogan 1999). Nigel Hartley has developed this work particularly in hospice settings (Hartley 2001) and with Gary Ansdell ensured that the theme was prominent at the last Music Therapy World Congress in Oxford. In the world of music therapy, the importance of spiritual considerations is evident in the early work of Helen Bonny as a central plank of her approach (Bonny and Pahnke 1972) and Susan Munro’s pioneering work in palliative care (Munro and Mount 1978).

In the December issue of Music Therapy Today (link), we published Lucanne Magill’s response to Michael Mayne at the World Congress in Oxford, July 26, 2002. She reflects on what she believes is really the heart of what we do, music therapy in spirituality. As she says, “So much of what we do is beyond words and it is really because of this transcendental nature of music that important healing in music therapy can and does occur”. In her four themes in music therapy, she proposes that music
builds relationship, enhances remembrance, gives a voice to prayer and instills peace. In the presence of music, when transformations begin to occur and healing begins, that it is in the lived moments of music therapy that the essence of our work - music therapy, spirituality and healing - is experienced and known.

Her response was made from a long career of experiences with cancer sufferers and their families (Bailey 1983; Bailey 1984; Magill 1993; Magill 2001; Magill, Chung, and Kennedy 2000). Both of us emphasise the importance of the immediate family and the people working in the hospital ward. We refer to this as the “ecology of singing in an hospital setting” (Aldridge and Magill 2002) as this fits into both our career experiences in clinical practice and community work (Aldridge 1986). This ecology will also include the palliative care culture, as a broader team, but the ethos of the center as a whole. Anyone working with Lucanne will have seen that there are the possibilities to make music from the head physician to members of the ancillary staff. Music-making is not solely for the patients in this setting, healing lies in the whole culture (I am using culture here also as praxis- indeed culture is an activity that has to be performed).

The World Health Organisation has a comprehensive picture of what palliative care is emphasising a total care of patients where the disease is not responsive to curative treatment and acknowledges that both psychological and spiritual problems may occur (WHO 1990). The goal of palliative care being to achieve the best quality of life for patients and their families. From a wholistic perspective, palliative care “ affirms life and regards dying as a normal process; neither hastens nor postpones death; provides relief from pain and distressing symptoms; integrates the psy-
Music Therapy Today (online), available at [http://musictherapyworld.net](http://musictherapyworld.net)

In clinical practice, I am pursuing this work further with Lucanne Magill at Memorial Sloane Kettering Cancer Center. As a former community worker, promoting the arts with different people and their communities, then music therapy was no strange practice to me when I first came across it. From my work with the dying, and the suicidal, in the community I had understood that we must implement an ecological approach to understanding these phenomena (Aldridge 1987a; Aldridge 1987c; Aldridge 1991a; Aldridge 1991b; Aldridge and Magill 2002). Indeed, the reason why modern medicine is failing is because it often lacks such a perspective. Considerations of spirituality then are not unique to music therapy, there is, and has been, over the last two decades, an increasing vigorous debate over the need for spiritual considerations in health care delivery (Aldridge 1987a; Aldridge 1987c; Aldridge 1988; Aldridge 1996; Bailey 1997). There is an overlap between music therapy and several other integrative medicine approaches particularly in the use of breath and how this is applied in altering consciousness (Aldridge 2002). Based on this published work, Nigel Hartley asked me to speak at a series of symposia held at the hospice where he works in Oxford, and we have presented together at various venues. Our intention has been to sponsor the discussion of spirituality as a legitimate topic in music therapy, just as I have tried to do in the field of medicine (Aldridge 1987c; Aldridge 1991a; Aldridge 1991b). There is also a debate about spirituality in the online magazine Voices ([http://www.voices.no](http://www.voices.no)) initiated by Dorit Amir as a response to what she heard in Oxford, and this article is an extended...
Music therapy and spirituality; A transcendental understanding of suffering

reply to that debate and what I wrote in response to Dorit. However, the need for a consideration of spirituality in music therapy, and indeed in medicine, has been an argument that I have attempted to foster since the early 1980’s (at least in print, see Aldridge 1986-1989 and finally 2000 in the references).

My doctoral thesis in 1985 was concerned with an ecosystemic approach to understanding suicidal behaviour. Taking a spiritual perspective did not remove from this ecological approach but added another dimension. For those of us involved in the Family Therapy movement, core texts were the books of Gregory Bateson (Bateson 1972; Bateson 1978). Everything became process, system and ecology with the intention of stamping out nouns. We see this perspective in Christopher Small’s book “Musicking” (Small 1998) where he also references the same discourse as I have done in my earlier work. Indeed, I use culture as an ecological activity binding the meanings of individuals in relationships together, what Gregory Bateson refers to as an “ecology of mind” (Bateson 1972).

What we do as individuals is understood in the setting of our social activities and those settings are informed by the individuals that comprise them. Here too, the body, and the presentation of symptoms, is seen as an important non-verbal communication that has meaning within specific personal relationships that are located themselves within a social context. Symptoms are interpreted within relationships.

Much of my thinking has been influenced by Sufi writings (Marsham 1990; Shah 1964; Shah 1968; Shah 1983; Tweedie 1995). One of the authors often cited in relation to music therapy and spirituality is Hazrat Inayat Khan (Khan 1974; Khan 1983; Khan 1996). What has to be remembered is that Inayat Khan gave up his music to concentrate on his

spiritual teaching. Giving up music was seen as an important step in his spiritual life of detachment from the world. Similarly, Irina Tweedie also refers to music as being a worldly attachment (Tweedie 1995). Indeed, music is prohibited in some spiritual traditions and only allowed on special places at special times. The Afghan mystic and teacher, Rumi, who is also becoming eminently quotable, is often seen as the prime example of a teacher who uses music and dance to inspire his disciples and promote their spiritual development. Shah (Shah 1983) reminds us that this may only have been so because Rumi’s disciples, at that time and in that place were so fixed in thinking as an activity, and so physically lethargic, it was necessary to get them moving and thereby into activity. For those who developed a musical tradition from Rumi’s teaching, then the musicians and dancers were part of a ritual of healing but it did not necessarily mean that the identified patient participate in the music making. There were specific musicians for the job in hand and such traditions involved the whole community. Some recent writers have used Sufi movements as part of their own attempts to break from their own rigidity of thinking but this has been accompanied by a teacher as part of a particular guided activity at a particular time on their spiritual journey, not as a regular and fixed activity.

*Health as performed: a praxis aesthetic in an immanent context*

My thesis is that health, like music (Aldridge 2002), is performed. Indeed, the process of “healthing” can be understood as a dynamic improvised process like that of Small’s “musicking” (Small 1998). How health is performed depends 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. These meanings are concerned with body, mind and spirit. My intention is to set about the task of reviving a set of meanings given to the understanding of human behaviour that is termed spiritual. It is legitimate to talk about spirituality in a culture of health care delivery. Human beings perform their lives together in meaningful contexts of significant others that are nested within broader social contexts. The difference contexts of performance are related to an ecological understanding of what it is to be a human being amongst other human beings and will argue for a return to a sacred understanding of human beings and nature. In these instances, “God”, “the divine”, “the cosmos” or “nature” may be the name given to a meaningful immanent context in which life is performed.

Spiritual meanings are linked to actions, and those actions have consequences that are performed as prayer, meditation, worship, healing and in our approaches, music healing. What patients think about the causes of their illnesses influences what they do in terms of health care treatment and to whom they turn for the resolution of distress. For some people, rather than consider illness alone, they relate their personal identities to being healthy, one factor of which is spirituality. The maintenance and promotion of health, or becoming healthy, is an activity. As such it will be expressed bodily, a praxis aesthetic. Thus we would expect to see people not only having sets of beliefs about health but also actions related to those beliefs. Some of these may be dietary, some involve exercise and some prayer or meditation. Some will be musical. In more formal terms they may wish to engage in spiritual healing and contact a spiritual healer amongst the health care practitioners that they consult. Indeed, some medical practitioners refer patients to spiritual healers (Aldridge 1986;
Aldridge 1987b) or develop holistic concepts of health care (Aldridge 1988).

There is a link between religion and spirituality, that I argue extensively in my book “Spirituality, healing and medicine (Aldridge 2000b)” although the two are often confused. The same difficulty has prevailed in the medical and nursing literature where spirituality and religion are con-founded.

All major religions recognise a spiritual dimension and that is the relationship between the human being and the divine. We see this reflected in the Yin and Yang symbol of Traditional Chinese Medicine that emphasises the vertical relationship between the human and the divine, each in their manifestation containing a seed of the other and uniting together to form a whole. Similarly, the Christian cross reflects both the realms of horizontal earthly existence and vertical divine relationship. The difficulty lies in the explanations that are used for understanding when either a sacred ecology or the divine relationship is used, one is assumed to supersede the other according to the interpreter of events. Both are partial. Indeed, what many spiritual authors seek is to take us beyond the dualisms of material and spiritual, beyond body and mind, to realise that in understanding the relations between the two then we leap to another realm of knowledge. Indeed, the Buddhist concept of the “Middle way” is not to find some mid-point between the two, but to transcend the two ideas unifying them in a balanced understanding. This leap that goes beyond dualism is the process of transcendence. In its simplest form, there is a change of consciousness to another level of knowledge; in short, the purpose of spirituality is achieved.
Spirituality in a late modern sense is used consistently throughout the literature related to medical practice as an ineffable dimension that is separate from religion itself. A person may regard herself as having a spiritual dimension but this may not be explored in any religious practice. Central to these arguments is the concept that spirituality lends a unity and purpose to life (see Table 1).

My position is that if spirituality is about the individual, ineffable and implicit, religion is about the social, spoken and explicit. Such definitions are an attempt to explicate the practices whereby spirituality is achieved. Spirituality lends meaning and purpose to our lives, these purposes help us transcend what we are. We are processes of individual development in relational contexts, that are embedded within a cultural matrix. We are also developing understandings of truth, indeed, each one of us is an aspect of truth. These understandings are predicated on changes in consciousness achieved through transcending one state of consciousness to another. This dynamic process of transcendence is animated by forces or subtle energies, and music is a primary example, in some contexts, of such subtlety.
TABLE 1. Definitions of spirituality from journal articles

<table>
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<tr>
<th>Definition</th>
<th>Source</th>
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<tbody>
<tr>
<td>“Spirituality is defined in terms of personal views and behaviors that express a sense of relatedness to a transcendent dimension or to something greater than the self...Spirituality is a broader concept than religion or religiosity...Indicators of spirituality include prayer, sense of meaning in life, reading and contemplation, sense of closeness to a higher being, interactions with others and other experiences which reflect spiritual interaction or awareness. Spirituality may vary according to developmental level and life events”</td>
<td>(Reed 1987)</td>
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<tr>
<td>“Spiritual elements are those capacities that enable a human being to rise above or transcend any experience at hand. They are characterized by the capacity to seek meaning and purpose, to have faith, to love, to forgive, to pray, to meditate, to worship, and to seek beyond present circumstances”</td>
<td>(Kuhn 1988)</td>
</tr>
<tr>
<td>“The spiritual dimension of persons can be uniquely be defined as the human capacity to transcend self, which is phenomenologically reflected in three basic spiritual needs: (a) the need for self-acceptance, a trusting relationship with self based on a sense of meaning and purpose in life; (b) the need for relationship with others and/or a supreme other (e.g., God) characterized by nonconditional love, trust, and forgiveness; and (c) the need for hope, which is the need to imagine and participate in the enhancement of a positive future. All persons experience these spiritual needs, whether or not they are part of a formal religious organization”</td>
<td>(Highfield 1992)</td>
</tr>
<tr>
<td>“Spiritual: pertaining to the innate capacity to, and tendency to seek to, transcend one’s current locus of centricity, which transcendence involves increased love and knowledge”</td>
<td>(Chandler, Holden, and Kolander 1992)</td>
</tr>
<tr>
<td>“Six clear factors ....appear to be fundamental aspects of spirituality....those of the journey, transcendence, community, religion, “the mystery of creation,” and transformation”</td>
<td>(Lapierre 1994)</td>
</tr>
<tr>
<td>“Spirituality...pertains to one’s relationship with others, with oneself and with one’s higher power, which is defined by the individual and need not be associated with a formal religion</td>
<td>(Borman and Dixon 1998)</td>
</tr>
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To remain authentic to both traditional sacred texts and to the earlier part of this commentary, I would suggest the use of “truthing” rather than truth, in the way that I have used “healthing” rather than health. Truth(ing) being a cosmic activity related to the breathing out and breathing in of the creator, thus my previous remarks about life being analogous to music; “living as jazz” where we are constantly being performed as living beings (Aldridge 2000b). Thus, truth is an activity; truthing constantly being performed, and we are its examples. This separates us from the objective – subjective truth argument where either there is an objective universal truth “out there”, or an individualised truth “in here” and places into an interactive truthing that we live with others, of which we are part as we perform.

“Religious” is used as an operationalization, or outward manifestation of “spirituality” (see Table 2). There are spiritual practices that people engage in, these often take place in groups and are guided by culture. As a cultural system, religion is a meaning-seeking activity that offers the individual and others both purpose and an ability to perceive meaning. We have not only a set of offered meanings but also the resources and practices by which meanings can be realised. However, as Idries Shah

<table>
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<th>TABLE 1. Definitions of spirituality from journal articles</th>
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<tr>
<td>“....spirituality refers to the degree of involvement or state of awareness or devotion to a higher being or life philosophy. Not always related to conventional beliefs.” (p65).</td>
</tr>
<tr>
<td>“Spirituality is rooted in an awareness which is part of the biological make-up of the human species. Spirituality is present in all individuals and it may manifest as inner peace and strength derived from perceived relationship with a transcendent God or an ultimate reality or whatever an individual values as supreme (p124)</td>
</tr>
</tbody>
</table>

Music therapy and spirituality; A transcendental understanding of suffering 11
reminds us that we must be wary of confusing “spirituality” with what is manifested outwardly.

“The poetry and the teaching to which you have referred is an outward manifestation. You feed on outward manifestation. Do not, please, give that the name of spirituality” quoted in the story of “The Cook’s Assistant” Idries Shah (Shah 1969)p115.

The social is what is common to all religions, it offers forms for experiencing nature and the divine; for transforming the self that is the goal of human development. Consciousness, achieving truth, is a social activity dependent upon its embodiment in individuals. Culture is the specific manifestation of such social forms in symbols, language and ritual localised for temporal and geographical contexts, thus specific cults and cultures. In globalization, we have the dissemination of culture but without social forms related to human contact. Therefore we may spread the idea of spirituality but offer no forms for the achievement of spiritual understandings, which is the traditional role of religious forms in everyday life. The same goes for the idea of music therapy, the idea of musicking as a performative health practice is useless unless we find cultural forms (as in perFORMance) such that healthing may be achieved.

<table>
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<th>TABLE 2. Definitions of religion from journal articles</th>
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<tbody>
<tr>
<td>“The term religiousness has been used in operationalizing spirituality” (p336).</td>
</tr>
<tr>
<td>“By religious we mean practices carried out by those who profess a faith” (p303).</td>
</tr>
<tr>
<td>“the term religious will be used to denote the part of the process when spiritual impulses are formally organized into a social/political structure designed to facilitate and interpret the spiritual search” (p34).</td>
</tr>
</tbody>
</table>

(Reed 1987)                                                                                                    (Doyle 1992)                                                                                              (Decker 1993)

### TABLE 2. Definitions of religion from journal articles

<table>
<thead>
<tr>
<th>Definition</th>
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</tr>
</thead>
<tbody>
<tr>
<td>“Religion has a beneficial effect on human social life and individual well-being because it regulates behavior and integrates individuals in caring social circles” (p684).</td>
<td>(Idler 1995)</td>
</tr>
<tr>
<td>“Religion is considered by some to be of divine origin with a set of revealed truths and a form of worship” (p500).</td>
<td>(Long 1997)</td>
</tr>
<tr>
<td>“...religion is or has been a response to socially induced vulnerability, it is and always has been a response to the physical vulnerability of the body that has been the human condition” (p648).</td>
<td>(Walter and Davie 1998)</td>
</tr>
<tr>
<td>“Religion will not be defined in strict terms, but will be used to denote experiences, cognitions and actions seen (by the individual or the community) as significant in relation to the sacred” (p260).</td>
<td>(Ganzoovort 1998)</td>
</tr>
<tr>
<td>“Religiosity is associated with religious organizations and religious personnel”</td>
<td>(Lukoff et al. 1999)</td>
</tr>
<tr>
<td>Religion involves subscribing to a set of beliefs or doctrines that are institutionalized”.</td>
<td></td>
</tr>
<tr>
<td>“People......can be religious without being spiritual by perfunctorily performing the necessary rituals. However, in many cases, spiritual experiences do accompany religious practices” (p65).</td>
<td></td>
</tr>
<tr>
<td>“Religion is the outward practice of a spiritual system of beliefs, values, codes of conduct and rituals” (p1259).</td>
<td>(King and Dein 1998)</td>
</tr>
<tr>
<td>“Religion encompasses that which is designated by the social group as nonroutine and uncontrollable and that which inspires fear, awe, and reverence, that is, the sacred. Through ritual, one gains carefully prescribed access to the sacred, which is carefully protected from the mundane, routine, instrumentally oriented beliefs and actions of the profane realm. Because sacredness is socially confirmed, stemming from the attitude of believers...political ideologies, value systems and even leisure activities such as sports and art (are viewed) as sacred activities” (p407).</td>
<td>(Park 1998)</td>
</tr>
<tr>
<td>“In fact, re-ligio, from its roots, implies that ‘foundation wall’ to which one is bound for one’s survival, the basis of one’s being (p444).</td>
<td></td>
</tr>
</tbody>
</table>

*Religion has a beneficial effect on human social life and individual well-being because it regulates behavior and integrates individuals in caring social circles* (Idler 1995).

*Religion is considered by some to be of divine origin with a set of revealed truths and a form of worship* (Long 1997).

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<tr>
<td>“…religious life is an expressive, world-building activity through which we get ourselves together and find a kind of posthumous, or retrospective, happiness” (pxiv).</td>
<td>(Cupitt 1997)</td>
</tr>
<tr>
<td>“A religion is a shared view into the heart of the world, a perspective into the truth, but a perspective that is always also a veil. It is, moreover, not just a view or a perspective; it is a perspective that faces up to the fundamental mystery of the world more or less well” (p550).</td>
<td>(Gillespie 1998)</td>
</tr>
<tr>
<td>“Religion is a comprehensive picturing and ordering of human existence in nature and the cosmos” (p220).</td>
<td>(Joseph 1998)</td>
</tr>
<tr>
<td>“Religion = any symbolic system which influences human action by providing possibilities for ritually maintaining contact between the everyday world and a more general met-empirical framework” (p147).</td>
<td>(Hanegraaff 1999)</td>
</tr>
<tr>
<td>“…religion refers to faith, beliefs, and practices that nurture a relationship with a superior being, force or power” (p43).</td>
<td>(Emblen 1992)</td>
</tr>
<tr>
<td>“One definition...regards religion as a source of shared norms and values. This approach stresses the motive of belonging and the role of integrating the community system. Another definition...regards religion as the relationship between human beings and a postulated supranatural sphere of power. This approach stresses the motive of empowerment and the role of religion in legitimating societal authority. Religion may be part of the political system or a resource of power for the social agents” (p250).</td>
<td>(Riis 1998)</td>
</tr>
</tbody>
</table>

The process of truthing behind the spirit of music therapy will be expressed socially in its religious forms and the names that they are given. These forms will be inevitably corrupted, like all religions, as they appear at specific times, in specific places for particular peoples (even though the time may be centuries, the places inter-continental and the peoples varied). Only spirit remains. We have the same situation about the naming of music therapy currently and inevitably where forms have to be recognised (literally re-cognised) (Aldridge 2000a). Forms have to come into being; the process of forming is at the heart of perFORM ance.
This process, calling a religion by a name, and its associated divinity, is a political activity. So too is the naming of the performance of therapy.

**Beyond meaning – Transcendence and suffering**

Medicine, from the Latin root medicus is the measure of illness and injury, and shares the Latin metiri, to measure. Yet this measurement was based on natural cycles and measures. To attend medically, Latin mederi, also supports the Latin word meditari from which we have the modern meditation, which is the measuring of an idea in thought. The task of the healer in this sense is to direct the attention of the patient through the value of suffering to a solution which is beyond the problem itself. In this sense, the healer encourages a change in the sign of the patient’s suffering from negative to positive. We are encouraged to see the benefit of suffering in bringing us beyond our present understandings, which is also an understanding of the transcendental. This, I argue, is what happens in music therapy, particularly in the context of palliative care.

Transcendence is a “going beyond” a current awareness to another level of understanding. This does not necessarily imply a conventional set of beliefs, it is based upon an innate capacity that we have as human beings to rise above the situation. Boyd (Boyd 1995) makes his argument for a consideration of the term “soul” as separate from “spirit”. “Soul” is the subjective or inner person as a whole in the natural state, including the body as an inseparable part, and relates to the word “psyche” (p151). “Spirit” however refers to that which could be both inside and outside a person. Soul focuses on the secular self, spirit refers to that which brings the soul to transcend itself, from without or within.
The process of spiritual development can be seen as a “quest” or a journey. In medieval times, the quest for the Holy Grail was not for a material chalice but symbolised the search for knowledge as a vessel in which the divine may be contained. However, what confounds this issue today is that we equate questioning as an activity rather like the chatter of infants. Many spiritual traditions emphasise the importance of silence and non-activity where the appropriate question may be framed, an as importantly, the answer may be heard. Meditation, prayer and music have both been used to fulfil these functions. Silence is the core of music and was the reason that I gave my first music therapy book the subtitle “From out of the silence” (Aldridge 1996).

Techniques of questioning, as embarking upon a quest, are a the heart of both science and spirituality in the search for knowledge. However, both demand a discipline if answers are to be found. These appropriate methods of questioning have to be learned and the approaches taught. The answers however cannot be learned as prescriptions for they appear new to each generation and to the appropriate contexts.

**RELIGIOUS PRACTICE**

While the spiritual dimension may be separate from the religious, religious practices are said to provide a bridge to the spiritual, thus assuming that the spiritual is a realm beyond the religious (Lukoff et al. 1999). This spiritual dimension is seen as a relationship with a higher power experienced as internal and intensely personal that need not be associated with the formal external aspects of religion; transcending sense phenomena, rationality and feelings leading to a heightened state of consciousness or awareness. The danger is that what may be seen as “spiritual illuminations” in the raw condition of altered states of consciousness are imagined to be spiritual experiences. These can become addictive (Shah 1983;
Shah 1990) preventing any developmental change. Thus the need for a spiritual guide, emphasised in the great traditions, and reflected too in secular psychotherapy as a wise counsellor, to prevent the interpretation of emotions as spirituality. The same confounding of emotion and spirituality may also occur in the use of music, hence the prohibition of musical experiences in some religions and at some stages of spiritual teaching.

The ability to rise above suffering, to go beyond the present situation to a realm where life takes on another, perhaps deeper, significance is an important factor in palliative care, in the long term management of chronic illness and as central plank of psychotherapy. In the treatment of alcoholism, it is the recognition of personal suffering and the need to transcend the limitations of the self, to understand that we are “Not-God” (Kurtz 1979), as a process of spiritual awakening that brings about one of the vital steps in recovery. Deborah Salmon (Salmon 2001) refers to music therapy as a containing or sacred space that facilitates the process of connecting to that which is psychologically and spiritually significant for the patient, thereby transforming experiences of suffering into those of meaning.

TRANSCENDING THE CURRENT SITUATION

From the literature it is possible to piece together a process of spiritual change that emphasises the need to transcend the current situation. To achieve this there has to be a change both in thought and feeling accompanied by appropriate actions. This is expressed as a process of questioning, as a search for meaning. Such meanings take the searcher beyond what she is to a higher consciousness, or state of awareness, that is connected to the truth, which people refer to as “god”, “the divine”, “the supreme power”, or simply “that”. This is a spiralling process of development based on revealed personal understandings achieved through tran-

scendence, which lead to other understandings. Idries Shah refers to this process as a removal of veils to the Truth (Shah 1978). These veils that obscure the truth are formed either through indoctrination, that blinds us, or through the base aspirations of our subjective selves preventing subtle perceptions and higher visions. Religion itself may be a veil that hides the truth, although it claims to offer a public perspective into the truth. The task we face is how to make those veils transparent, or remove them. A further task is how to cope with the truth thus revealed.

The whole concept of pluralism, often invoked for justifying differing positions within the world of music therapy, is itself a term borrowed from theology. The basis of the understanding is that no one of us as human beings can begin to claim a full understanding of the divine (or what ever you may choose to call him or her), thus in all modest we have to recognise that we have only parts of the picture. A challenge is for us all to come together and merge those various understandings. This is recognised in the Christian perspective of “Though we are many, we are one body” (Aldridge 1987b).

SUFFERING AND THE LOSS OF A COHERENT SELF

We suffer when we fail to make sense of our experience. One of the difficulties faced by people in the advanced stages of cancer, or the neurodegenerative disease, is that they lose their sense of dignity. Pullman argues that this is an aesthetic perspective on suffering (Pullman 2002) and proposes that maintaining a meaningful life is an aesthetic project.

The spiritual elements of experience help us to rise above the matters at hand such that in the face of suffering we can find purpose, meaning and hope. It is in the understanding of suffering, the universality of suffering and the need for deliverance from it that varying traditions of music ther-
apy and religion meet. 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.

While we may strive for the eradication of major diseases, the presence of suffering will be a part of the human narrative. So too, then, the relief of that suffering. How that relief is achieved will not be dependent solely upon a medical narrative but, as the major religions have offered throughout the ages, also upon spiritual understanding. We are all asked the ultimate question of what meaning and purpose our lives would have had if we were to die now. Most of our activities cut us off from this brutal confrontation, or are an attempt to shield us from this realisation. While the management of pain is often a scientific and technical task, the relief of suffering is an existential task. In the major spiritual traditions suffering has always had the potential to transform the individual. As Tournier (1981) reminds us, it is love that has the power to change the sign of suffering from negative to positive.

_Coda: Therapist heal thyself_

There are different methods to approach truth. If we accept that in a modern vibrant culture there is a pluralism of truth claims, then a major task will be for us to reconcile what may appear to be disparate ideas. The argument here is not for some kind of homogeneity of thought but for an acceptance of the tension between ideas as a creative arena that pushes us beyond what we know. Thomas Merton (Merton 1996) writes in his journal for the 28th of April 1957
“If I can unite in myself, in my own spiritual life, the thought of the East and West of the Greek and Latin fathers, I will create in myself a reunion of the divided Church and from that unity in myself can come the exterior and visible unity of the Church. For if we want to bring together East and West we cannot do it by imposing one upon the other. We must contain both within ourselves and transcend both...” (p87).

My hope is that we can go some way to uniting the “East” and “West” of thinking in music therapy such that there is a reunion of thought about healing and the possibility of transcendence. This perhaps is the basis of healing and the core of hope. As Merton suggests, one cannot be imposed upon the other, it is the containment within ourselves that brings the change. This is simply an argument for diversity in the culture of music therapy that includes the many facets of its performance. In the same vein, I am not arguing against modern health care delivery, nor scientific methods, but for the development of an applied knowledge that relieves suffering and promotes tolerance and includes the creative arts therapies.

If each one of us is a living performed truth in itself, then other truths are made possible through relationship as encounter. Through this encounter with a living universe, we expand into an ecology of knowledge. Through music we have the possibility of peforming this encounter; we literally bring truth into a temporal, albeit ephemeral, form. This is the unity of consciousness, becoming whole and the basis of the healing endeavour. As each person progresses, wholeness is achieved at a different level of understanding. These understandings may be horizontal in a natural ecology, vertical in a divine ecology, or both. Spirituality enables the transcendence from one level to the next incorporating new perspectives and reconciling contradictions. Thus we become whole as a person;
realising that our relationships have to be healed, we become reconciled as a community; realising that there is strife and discord, we search for political accord; realising that there is imbalance and a lack of harmony, we search for a reconciliation with nature; realising that we are alone we reach out to the cosmos.

**Literature**


Music Therapy Training
Aotearoa – Embracing and Accessing a World of Perspectives

Robert E. Krout

Abstract

This article is a brief sharing of perspectives, observations, and information from an American-trained music therapist who has moved from West Palm Beach, Florida to Wellington, New Zealand to help launch and direct New Zealand’s first dedicated university music therapy training programme. The Massey University Master of Music Therapy programme, and how international perspectives in music therapy will be reflected, accessed, and included in that programme via technology and the World Wide Web are described. The concept of perspective is briefly discussed and used to tie together various themes throughout the article.

The concept of perspective relates to how we see and experience our world. The term is most often used as a noun, with origins in Medieval Latin and Middle English relating to sight and the ability to see clearly
For example, in the 14th century, an optical glass or telescope was sometimes referred to as a perspective (Merriam-Webster, 2003). As music therapists, the concept of perspective may relate to how we see and perceive the therapeutic environment, our clients and their needs/progress, the music created as part of the creative process, the concepts of change and growth, what is therapy, and many other aspects of our work, field, and profession. These perceptions can in fact be seen as central to who we are and what we do as agents of change within the field of music therapy (Bruscia, 1998; Eagle, 1991). While changes in perspective can range from minute and almost imperceptible to obvious and life-altering, some are easier to anticipate and/or be aware of than others. I have recently experienced (and am continuing to undergo) a constellation of dramatic shifts in perspective after moving from Florida to Wellington, capital city of Aotearoa New Zealand in July, 2002 (Aotearoa is the indigenous Māori name for the country we call New Zealand). I undertook this journey to help set up and implement the Master of Music Therapy Programme here at Massey University.

The concept of representing international perspectives on music therapy in this training programme has taken on a central meaning and importance for me. Music therapy is increasingly being seen as a "world community" (Grocke, 2003). With the launch of a new university programme comes the challenge of making sure that "global views" in music therapy are embraced and accessible for students during their education and preparation. This is indeed an exciting time for world music therapy and music therapy in New Zealand, with the concept and perspective of a global music therapy community being increasingly realized. This is in part through international sharing of information and ready access to information via technology and the World Wide Web.
Some brief background information on music therapy in New Zealand may be helpful. Even though our Massey programme is the first dedicated music therapy degree in the country, music therapy as a professional field is not new to New Zealand, and in fact dates to the mid-1970’s. Since that time, music therapy has continued to grow, develop, and evolve here. There are at present a small but dedicated number of music therapy clinicians practising in diverse client needs areas and settings, music therapists involved in research, a fine professional music therapy organization (the New Zealand Society for Music Therapy was formed in 1975) with several regional chapters throughout the country, an annual national conference, and an excellent annual journal. There has been interest in establishing a university training programme for some time. The Master of Music Therapy (MMusTher) programme at Massey is in fact the result of 18-plus years of the activities and concerted efforts of clinicians, educators, researchers, and other supporters (Croxson, 2003, 2002, 1997, 1993). Up until now, some Kiwis (New Zealanders) have ventured abroad to study music therapy in a number of countries and return to New Zealand to establish clinical positions. Others have remained in the country and taken part in individualized courses of study approved by the NZSMT. A number of international music therapy clinicians, researchers, and educators have travelled here for such trainings, as well as to present at conferences, workshops, and professional development courses. In addition, prior to the Massey programme, a music therapy training and endorsement were also for some time offered in the country as part of a Diploma in Teaching at the Palmerston North College of Education under the coordination of Morva Croxson (Croxson, 1997). A national music therapy accreditation process was also developed, with an independent registration board established in 2000 by the NZSMT. The current status is that there are approximately 18 trained and creden-
tiated music therapists currently active in New Zealand. Again, this is just a brief bit of background information. For more detailed information on the overall development of music therapy here in New Zealand, the reader is referred to the writings of Croxson (Croxson, 2003, 2002, 1997, 1993).

The implementation of our Masters of Music Therapy Programme is thus a milestone for music therapy in Aotearoa. It has begun to, and should continue to affect the perspectives of many, including this author, current and future Kiwi music therapists, clinical facilities and settings, and the culture of healthcare and education in New Zealand society. As an American-trained music therapist, moving half way around the world to work, teach, and practice in a new country is needless to say a significant change of perspective. Coming from a music therapy community in the U.S. which includes thousands of music therapists, 70+ university programmes, and over 150 internship sites to a national community of around 20 music therapists is also a tremendous shift, change, and challenge. I feel an enormous sense of responsibility to make sure our university programme represents a diverse, thorough, and international or “world” approach to the best of music therapy. As the only university programme in the country, it is our responsibility to make sure students get a well-rounded experience. The core of that experience will include training that follows the educational training standards, guidelines, ethics, and competencies outlined by the NZSMT and the Music Therapy Registration Board, as well as guidelines of organizations such as the World Federation of Music Therapy. The two-year Massey MMusTher degree includes studies in music therapy principles, music therapy methods, special topics, study of music of indigenous cultures, practicum, casework, and research. Bachelors-level studies and abilities in music, as
well as additional psychology coursework are required prior to entry. Fairly rigorous audition and interview standards have been implemented, and a minimum of 1,200 hours of supervised clinical practice (across age and needs areas) are required prior to graduation. Registered Music Therapists (RMTh’s) across the country will work with and supervise student practica and field placements, along with the author and Massey music therapy tutors. Unique issues facing New Zealand music therapists and the clients they serve will be blended with world perspectives.

As previously mentioned, the NZSMT has helped to ensure that international perspectives and approaches have been included in the education and professional development of clinicians since the establishment here of music therapy in the 1970's. Many international presenters have travelled here to teach, present, and work with students and clinicians. In addition, invaluable guidance has for a number of years been provided from Dr. Denise Grocke of the University of Melbourne in shaping an overall curriculum template for the music therapy training programme that was approved here at Massey University.

So - to the future and our therapists in training. To help to continue to bring this rich representation of international perspectives into our Massey programme means making sure that students are aware of and make use of training materials and resources from various countries that represent various approaches to/perspectives on music therapy. Fortunately, this is a wonderful time to be starting a new university programme in terms of available international educational materials and resources via technologies such as the World Wide Web music therapy website features include research databases, columns, links, downloads of resources such as collected papers, videos, conference reports, spotlights on various

Music Therapy Training Aotearoa – Embracing and Accessing a World of Perspectives
countries, dissertation databases, and more. An especially exciting format/resource is the discussion board forum and platform, where therapists and students can post and respond to questions, share views, and interact with others around the world. This ability to continue open, ongoing, and continuous discussion and interchange can connect clinicians, students, and others in a unique and inclusive manner (Kenny & Stige, 2001).

Websites from music therapy organizations around the world are also useful as resources for sharing international perspectives with students. There is also a valuable ListServ for music therapy students interested in international issues (mtstudentworld@yahoogroups.com). These and other resources will prove invaluable in bringing international on-line perspectives into our New Zealand university programme. They will also enable our students to reach outside our borders to interact with music therapy students world-wide.

This is also an exciting time in terms of available music therapy publications that can be used in teaching. There are a number of recently-published music therapy texts that will help ensure that students are aware of music therapy clinical methodology and approaches from authors in various countries.

We are also especially fortunate in New Zealand to have our Australian colleagues located just across the Tasman Sea. In addition to formal and informal sharing and collaboration described above, there have been and will continue to be presentations by Australian therapists at NZSMT conferences and vice-versa (presentation by Kiwi therapists at conferences of the Australian Music Therapy Association). Our national journals are also forums for sharing and educating. It is also fortuitous that the 11th
World Congress of Music Therapy, sponsored by the World Federation of Music Therapy and planned to take place in Brisbane, Australia in July, 2005.

To summarize, one unique challenge and opportunity we face in New Zealand is preparing music therapists to serve clients in this country with a comprehensive training that includes perspectives from around the world. The above approaches represent just some of the ways that international music therapy perspectives will be embraced in our new music therapy programme here at Massey University. I am both proud and humbled to be able to take part in the global music therapy culture from a new perspective - music therapy Aotearoa.

References


Address

Robert E. Krout, Ed.D, MT-BC, RMTh

Music Therapy Programme Leader

Conservatorium of Music
Massey University
Private Box 756 Wellington
NEW ZEALAND

R.E.Krout@massey.ac.nz
Editorial Music Therapy Today Vol. IV, Issue 2, April 2003

We have taken a look back and found that we are going into our fourth year of publishing this online journal. Our editorial and scientific advisory board is constantly growing and we are proud to offer you this service for publishing your work.

We have decided to renumber our issues. This issue is “Music Therapy Today” Vol IV, Issue 2 April 2003!!! We started out as a newsletter called ‘Research and Practice News’ that we published in Autumn 2000. Up to now we have approximately 800 pages of research and practice articles.

A sample copy of the complete issues will be published on our forthcoming Info-CDROM V that will have its official release date at the EMTC conference in Jyväskylä, Finland in June 2004. You can read more on the Music Therapy Masters Program at University of Jyväskylä, Finland here.

This issue focuses on the use of guitars in music therapy. The guitar
has become very popular during the sixties and is one of the most used instruments in popular music. No wonder that most of the articles refer to popular music issues, songs recorded by famous musicians and musical styles promoted by different playing of this instrument. ‘Punk music’ encouraged people to play guitar. It is easy to use and to learn and you just need to know three chords to express yourself in a song. To make music it is not necessary to read a score. Many styles are becoming popular because access to the aesthetic practice of making music is made easy, whether it is using a guitar, a computer program, a drum kit or a beat box and a microphone. As long as someone has something to say musically it is not need prolonged musical studies to be able to express yourself in music. Maybe this is one reason why instruments associated with such a ‘democratic’ approach took a long time to be positively recognized from trained musicians.

The first article “Men and guitars - Personal experience with the guitar in music therapy” comes from Bob Romanowski, a music therapist working in Berlin. He describes his personal experiences with the guitar, his fascination raised by listening to the Beatles as a child, during his time as a professional musician and as a music therapist now working in forensic psychiatry and with mentally handicapped people. Five single cases demonstrate his way of using the guitar in therapy. He has
provided some sound files as well. He also introduces the idea of transference lines, a Buddhist concept for the acceptance of a healer, a monk or a priest in a certain spiritual tradition. His recording with a patient singing is our featured Music Showcase.

The next furious article “The Guitar In Palliative Music Therapy For Cancer Patients” comes from Alessandro Ricciarelli, a music therapist working in the Sloan Kettering Memorial Hospital in New York City. This article is the third feature of work done at this music therapy unit.

In our last issue we featured a song recorded during his work with Jonathan in our Music Showcase. In this article we can read about the use of guitar and songs in palliative care. Alessandro works together with Lucanne Magill. Alessandro, as an excellent guitarist, shows his very sensitive and gentle way of being a companion to the patient, as you can hear music files included in the article. For those sharing the evenings in Keble College at the World conference in Oxford you might remember his excellent playing and singing of mostly every song he was asked to play. Here, he shows his reflective ability to condense his thoughts on music and therapy and what it means to serve the patient and the music.

In our next two articles enhancing instrumental practice and ideas is the
main topic. We need to share this knowledge as a resource on the web to establish a forum of teaching material. This material is accessible for students and practitioners to gain skills and ideas for their upcoming work. We invite you to participate in this knowledge too, so please write your articles and send them to us here!

Robert Krout is currently working at the Massey University in Wellington, New Zealand. He has shared his ideas for a music therapy training course in our last issue. He writes about his ‘top ten’ techniques working with guitars in music therapy. His article “Essential Guitar Skill Development Considerations for the Contemporary Music Therapist” provides a lot of hints and useful exercises. He also suggests some useful links and resources for those interested to gain more instrumental skills on guitar. Having published a series of articles and books on the use of guitar in music therapy we are very proud to have his experience in this article. Sound files tabulator scores and photographs can be obtained from his books. Get your guitar and read at the same time and then you might guess what ‘Netucation’ could be.

Please do not put the guitar away before Roy Kennedy has given you the second lesson for today: “Guitar Skills for Music Therapy Majors”.

Roy Kennedy is currently Director of Music Therapy at The University of
Georgia where he teaches core courses in music therapy. He too offers us more skills and tips how to improve our guitar playing. We might find this amusing, especially as the guitar is often associated with campfire singalongs, ‘simple’ pop music and singing hobos on the street we might question the need to give hints on how to use the guitar properly in music therapy. Roy does this in a very structured and skilful way and after you have been through his lessons your fingertips will be glowing…

To get back to live music and skilful players, I am happy to announce Petra Kern’s interview with jazz guitarist Steve Abshire. Steve Abshire is a jazz guitarist, teacher, and clinician in the Washington D.C./Baltimore area. His experience as a clinician and musician makes him predestined to be heard in this journal. In this interview we are going to use the web advantage of multimedia. This time you will not read his thoughts but hear his voice and you can listen to a live concert from him and his band at the East Coast Jazz Festival 2003 in Washington D.C.

Writing these lines I heard that the war in the Middle East has begun. All my best wishes go out to those in the fields. Thinking about songs of relief my thoughts immediately turned to

“Imagine all the people, sharing all the world”

… BUT …
“you may say I am a dreamer, but I am not the only one” …

(John Lennon)

Until we read again

Joerg Fachner
Men and guitars - Personal experience with the guitar in music therapy

Bob Romanowski

Abstract

Why is the guitar so attractive to some people? The author describes at the beginning what he personally felt and is feeling still, and how he accounts for the effects. He introduces the idea of transference lines by explaining fascination and action of the guitar. The clients he describes will probably have their own ideas on what fascinates them about a guitar. This question is of particular interest for him with regard to mental handicaps. He supposes the attraction is due to the very basic stimulating qualities of this instrument, and is revealed on various levels.

Song of praise to an “object of power”

“My God is rock’n’roll. It’s an obscure power that can change your life. The most important part of my religion is to play guitar.”

1
Everything starts for me with a drab Sunday afternoon in ca. 1965; I am sitting in our living room, absolutely spellbound by the TV screen. The weekly magazine “Wochenspiegel” ends with a report on a music group performing in a lion cage. Four men, three of them having buckled on electric guitars, are playing a song entitled “Help”. The fourth musician is sitting in front of his “shooting gallery” armed with drumsticks. The lions are being tamed with the help of these magic instruments, they are bored and yawning.

Adolescent music fans reacted to the “fabulous four”, as the Beatles were also called in allusion to their super hero powers, in a quite different manner. Female teenagers in particular went into hysterics.

This mythical image (Daniel in the lions’ den) directed my interest and my longing to the guitar, this object of power, with the help of which it is possible to triumph in seemingly fatal situations (in the danger of being devoured) and thus become a hero. The guitar is a hero’s attribute, like a sword, a spear etc., but in contrast to these it is endowed with a positive and creative power. It does not destroy the hostile object, on the contrary: it creates something, a sheltered sphere, a protective force … comparable to an invisibility cloak or a magic wand.

I grew up accompanied by such heroes. They were men with guitars. I remember Rory Gallagher making his way through a crowd, head down, two scratched Fender guitars hanging from left and right shoulder on belts. On the stage, supported by the earthing powers of bass and drums, he set off a firework that moved the audience to attention, abandonment

and enthusiastic applause. Jimi Hendrix was another pyrotechnics artist; in a state of ecstatic trance, eyes closed, the incarnation of a god, standing in front of a wall of Marshall amplifier towers, plucking and wringing the pure electric male energy out of the slim body of his Fender Stratocaster guitar.

FIGURE 1. Jimi Hendrix in a trance during a guitar solo

This dream body of the guitar appears alternately as a phallic symbol or a female body. My instincts are those of a guitarist. For me, the guitar is more female in nature – B.B. King calls his guitar “Lucille”. It is a body which the guitarist charges with his male energy so that the liberating sound may be born out of it.
In the process of appropriating the guitar and the pertinent cult of the guitar, I received the transference from a long line of men, men like: John Lee Hooker, Eric Clapton, Hubert Summlin, Howlin Wolf, Volker Kriegel, Rob Krieger, John McLaughlin, Jerry Garcia, John Cippolina, Carlos Santana, Hannes Wader, Bob Dylan, Muddy Waters, Lightnin’ Hopkins, Keith Richards, Lou Reed, Mick Taylor, Greg Allman, Tom Fogerty, Pete Townshend, Neil Young, Ali Farka Toure, Jeffrey Lee Pierce, Howe Gelb, Billy Bragg … a list that could go on. But my intention was to pay my respects to these special heroes of mine, all of them men who entered the stage (the real or the virtual stage) with their instrument, unfolded their magic and left me with an impression that caused me to draw the dream body of the guitar to me and to touch the strings again and again and for thousands of hours.

What I attempt to describe here is a personal experience, and influenced by the transference line of a certain knowledge. A knowledge that may also be called a power. The knowledge of it and the power to change or transform certain realities of experience. The transference line I mention is that of blues and rock’n’roll and some variants of this kind of play.

**Transference lines**

The principle of the transference line applies not only to guitar music but basically to all forms of human tradition. (This concept is borrowed from Buddhist terminology\(^1\)) Participating in a transference line means that I enter into a tradition of human civilization and am thereby connected to and rooted within a cultural network of human relations. When I take up

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1. Sogyal Rinpoche, 1995: Das Tibetische Buch vom Leben und Sterben, O.W. Barth Verlag
an instrument and learn how to play it, I link up to a transference line. The most simple techniques, e.g. touching a string, follows the transference line over a chain of individuals back to the very first guitarist or player of a string instrument. We may say that there is an energetic connection.

The knowledge that is transferred to me comes from the past and was taken up, cultivated, developed and passed on over a long line of practicing musicians. In practical music-making on a guitar, this knowledge comprises many partial aspects to which I am initiated in a lengthy process. The origins of this transference are not known to us, but nevertheless a direct connection certainly exists. This is why I may call this phenomenon of transference a transfer of energy, a flow of subtle energies. Just by taking up a guitar I enter into contact with this transference line, enter into the aura of the guitar. The guitar and its pertinent cult may thus become a source of power for the guitar player. The essential knowledge of a guitar player is about how to canalize and express one’s mental energy (feelings, emotions, thoughts). I handle feelings, emotions, thoughts in a very specific manner. I express them in giving them an illustrative form that uses the guitar – in this case – as an instrument or tool.

Some characteristics of the guitar.

A guitar is a box of an antromorphous form, vibrating and resounding (a resonant body) that is brought into vibration through plucking the strings stretched over the instrument. To play, I place this box on my lap and hold it against my stomach and chest so that the vibrations are transferred to my body. In blues and rock music, which I address here specifically,
this “vibrating massage” of the trunk is maintained continuously with rhythmic beats. This form of practice also involves a monologic song in which the player expresses his feelings, emotions and thoughts and thus gives them an external linguistic form. The result is emotional relief; events are processed and self-confidence is improved.

/Audio document No. 1: John Lee Hooker “My first wife left me” on The Blues Legend, Timewind 50031/

In my experience, the swinging resonant body of the guitar also helps to open up the voice. The guitar has the effect of an external vocal support, an amplifier.

The guitar thus becomes an “object of power”. The act of acquiring his guitar is important to a guitarist and full of significance. Is it a very specific present he receives, or must he make an effort himself, must he overcome obstacles in order to buy his instrument? A guitar player associates memories, anecdotes, meaningful episodes with his instrument and the way he handles it. With this object of power he creates sound spaces, dream spaces, spaces for emotion and for coping. Not only the demigods, the heroes of the guitar are important for a guitar player in his process of incorporation, but also the social network of his peers, the “adepts” with whom he exchanges knowledge (about guitars, riffs, licks, tricks, etc.) and with whom he adds to the myth of the guitar. The guitar thus becomes a companion and supporter for life.

Woody Guthrie, an American forefather of protest songs, saw the guitar as a weapon against “evil”. He had written on his instrument “This guitar kills fascists”. Young guitarists charge their instruments in a similar way when they scratch their messages onto the corpus (“Punk rules” or something like that). The guitar as an expressive means of male power also
does good service in courting a woman. A love-song, supported by the magic sounds of the guitar, reaches out for the adored one on an emotional level. The guitar augments the potency of the courtship. In times of need and loss, the guitar can assist me in bereavement or comfort me, as a kind of transitional object.

**The guitar in music therapy**

What is the significance of the guitar for music therapists? What I have incorporated in that process of assimilation and coming to terms with the guitar cult, this is what I carry with me in a patient encounter and what I can contribute to the joint therapy process. It is the ability to employ my feelings in a form-giving, coping manner, to change or charge them or to trigger off a release, to stir them up or to calm them down. And all this with my guitar as an object of power.

**CASE STUDY 1**

Several examples taken from case histories will illustrate my experience with the guitar in music therapy.

One of my responsibilities is psychiatry with prison inmates. In an open music therapy group with five men aged ca. 20-45, I had a patient diagnosed with polytoxicomania or multiple drug dependence, drug-induced psychosis. Or more colloquially: “a junkie”. In the first few sessions the man appeared withdrawn and suspicious. His participation in our musical activities was reluctant. In improvisations he played the maracas, and his contributions to group discussions were monosyllables. In one session I suggested we listen to a piece by Jimi Hendrix. “Hey Joe” is a blues ballad about a man who shoots his girlfriend because she has affairs with other men. This song, originally by Billy Roberts, was interpreted by var-
ious artists in the 60es. Jimi Hendrix made it famous with his brilliant guitar solos.

/Audio document No. 2: Jimi Hendrix “Hey Joe”/

Having listened to the song together, I realized that my client was deeply touched emotionally. With tears in his eyes he told when prompted that he had remembered acquaintances from his drug career from years ago, some of whom now dead. In the next therapy session he asked me to play the song on the guitar, and he was willing to join in the performance. Afterwards he was in a positive mood and complimented me on my playing. We were thus able to establish a basis for a therapeutic relationship where I was able to help my client to gradually come out of his acute depression.

This underlines the importance of a music therapist’s “individual ressources” for practical therapy. In the described case, the important point were the musical repertoire and the ability to project himself into the mind and background of the client in order to select an appropriate song. The guitar helps me to build bridges to my clients and to encourage them to get involved in therapy, in particular in the joint music-making.

In the past year I had two opportunities to use the guitar exclusively in single therapy sessions. Both patients had been diagnosed with drug-induced schizophrenia.

CASE STUDY 2

It was impossible to integrate the first patient, an extroverted Reggae fan and continuously active and moving around, into a therapy group; he had almost no self-discipline and drew attention to himself all the time. Music was a central theme of self-definition to him. In his manic omnipotent fantasies he saw himself as a famous popstar in front of an audience.
of millions. When the opportunity arose I offered to give him guitar lessons in a single session per week. I hoped this method might help to get him down to earth, to train his impaired ability to concentrate, and to direct his erratic thoughts to one task.

Reggae superstar Bob Marley was his idol. The identification with this guitar hero motivated him to tackle this new task of learning to play the guitar. It was a pleasure to observe the tremendous interest with which he addressed this objective and his growing ability to concentrate. Our joint project helped him to develop a positive attitude towards me and to accept that I made suggestions for his everyday behaviour. He started to take more care with his personal hygiene and his appearance; he had his papers ready for the guitar lessons and was not in bed at the appointed time but up and dressed and waiting for me in order not to lose time. In his case, music therapy provided a contribution to reorientation in reality, to coping strategies and reintegration into a regular life.

CASE STUDY 3

The second patient was an introvert and tended to withdraw into his cell. He appeared suspicious and insecure. In a first session when I accompanied his play on the maracas on my guitar, he told me “I have always wanted to play the guitar, but somehow nothing came out of it”. So we agreed on guitar lessons for him.

My client had attended a special school only and showed serious learning deficits. He had difficulties coping with abstract concepts. When I drew a finger position diagram, e.g., he required much patient help to understand how to put his fingers on the guitar accordingly. My intention was to “charge” the client with attention and friendly consideration and to give him a sense of achievement in order to boost his low self-esteem. I
wanted him to feel accepted and encouraged without having to give something in return. This was to establish a basis for personal growth.

It must have been after the 10\textsuperscript{th} session when he made a first positive comment on his progress. I gave him small tasks to perform as homework. He was, e.g., asked to write down the song text of “Marmor, Stein und Eisen bricht” in his cell and to exercise the transfer from the visual to the motoric aspect; I was impressed to see in the next session that he had actually implemented my suggestion. (His physician told me later that he had categorized this patient as dyslectic. He had said he was unable to write.) I took this development as an indication that he was on the way to overcome his depression.

\textbf{CASE STUDY 4}

Two guitar players with serious mental handicaps are the next cases I want to describe. A blind man had come to my attention in a music group organized in a sheltered workshop. He asked repeatedly to be allowed to play my guitar. He left his seat in the group and with outstretched arms made his way across the room towards the guitar; as soon as he touched the strings he stood still and started to strike the strings with even movements. In a demanding voice he just said “Guitar!” and giggled with delight. Whenever there was some time left after sessions, I put the guitar in his lap. He held it safely in his arms and started a continuous bourdon sound with even striking movements of the right hand. In a peculiar nasal singsong he simultaneously voiced a text about events in his daily life and its highlights. As a consequence of developmental difficulties in early childhood, his vocabulary is limited and his syntax very simple. “With the tram – hospital – Dr. Müller – not hurt.” He repeats such chains of ideas again and again in his song, lines up several sentences, uses parts from other songs he knows. He uses the material as it occurs to him spon-
taneously. On the whole he thus creates a musical form which reminds me of certain musical traditions, like blues. The way this man gave himself over to his music impressed me very much. He became completely absorbed and went into an ecstatic trance. He started to perspire, his face showed great agitation, almost obsession and thus resembled that of famous artists in their performance. The adverse effect was that he lost all self-control and was unable to stop. I heard later that he had repeatedly destroyed his instruments in such states of agitation and had even injured himself.

An opportunity for music therapy sessions was created for him at the institution where he lived. His carers had noted his tendency to self-injuries (old marks of biting on the back of his hand). We defined as a therapy objective to encourage his ability to control states of agitation. I was in favour of buying a guitar for him. He was beside himself with joy over this Christmas present, very proud of his guitar, and came to therapy sessions highly motivated. Soon I had to give up my original idea to give him guitar lessons in the traditional manner. He was unable to cope. I tuned the guitar strings openly to a chord and let him accompany simple folk and children songs in his resulting bourdon style. I saw to it that he learned to start and conclude a song jointly with me. The beginning and the end of each lesson were also clearly marked by specific songs. In the course of the therapy I observed that the inner tensions that had caused his self-injuries were reduced to such a degree that his wounds were allowed to heal. He was able to control his agitation better. Mentally handicapped persons in particular require regularity and predictability of events. A therapy session per week helps to structure time and creates more security. An individual pastime supports identity and a feeling of “being myself”. An additional carer is an additional anchor in the social
environment. I do not mean that the guitar alone was the reason for all this, but it accompanied this development, was associated with it and will continue to do so.

**CASE STUDY 5**

Another inhabitant of the same institution also demonstrated the strong fascination the guitar had for him. This man was also blind, with a severe mental handicap, and hardly able to speak; but one of his approximately ten identifiable words is “la-la-la” and means music. Whenever I took up the guitar to accompany my singing, he came crawling in my direction in order to play himself. He found the drums interesting as well, but the guitar had his specific attention. After some time we have established a therapy routine with him sitting on a mat with a large pillow where he may lay down from time to time to have a rest. The guitar is within his reach and he plucks at the strings with his hand.
FIGURE 2. The pictures show a handicapped guitarist. Compare it with the Hendrix photo. Doesn’t the face show the same trance?
We make music according to the “call-response” principle. When he has started to touch the guitar, I answer with a few notes on my guitar, or with beats on the drum.

/Audio document No. 3, handicapped guitarist/

Once I recorded such a session and gave the cassette to the staff at the institution. When my client was in a bad mood in the course of a day, they played the cassette to him on his recorder and observed that he listened very attentively and soon was in a better mood. Therapy in his case is accompaniment and also a highlight in the patient’s day. But it also means improved quality of life. As a therapist I am in a somewhat better position – compared to the staff – to focus on the quality of our relation-
ship as the centre of our interaction and thus to make a specific contribution to the way this severely handicapped man experiences his surroundings.

The guitar is again the appropriate medium to provide access to this client in a very specific manner.

**Conclusion**

Why is the guitar so attractive to some people? I described at the beginning what I personally felt and am feeling still, and how I account for the effects. The clients I described will probably have their own ideas on what fascinates them about a guitar. This question is of particular interest for me with regard to mental handicaps. I suppose the attraction is due to the very basic stimulating qualities of this instrument, and is revealed on various levels.

Personally, I now even use the Internet on my search for lost guitarists, their tricks, licks and stories. But in the end I always find myself with the “dream body” in my hands, because I want to play something again, or because I want to explore a specific idea, a feeling. And ultimately because I just feel that I am part of this tradition of the large global community of all musicians in general, and of the “men with guitars” in particular.

Proviso: The clients described here are no real persons but constructs of various differing personalities and their individual qualities.
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INTRODUCTORY DISCOGRAPHY:

Quicksilver Messenger Service – Happy Trails

Captain Beefheart – Ice Cream for Crow

The Jimi Hendrix Experience – Are You Experienced

The Greatful Dead – Dead (Live)

John Lee Hooker – Blues for Life

Ali Farka Toure – Radio Mali

The Velvet Underground – The Best of the …

The Doors – Strange Days

The Gun Club – Fire of Love

The Go-Betweens – Liberty Belle and the Black Diamond Express


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The Guitar In Palliative Music Therapy For Cancer Patients

Alessandro Ricciarelli

Memorial Sloan-Kettering Cancer Center,
New York City

Author’s note: The pronouns ‘he’ or ‘she’ are used randomly when referring to the genders of patients, music therapists, nurses or doctors. When describing music therapy experiences with patients, however, the pronouns ‘he’ or ‘she’ are used according to the respective patient’s actual gender, because it is important contextual information. In order to protect the patients’ privacy, their real names have been changed.

Abstract

The music therapist in a cancer hospital is in the unique position to work with patients and their families and friends in ever changing settings and with widely varying therapeutic goals. The therapy might aim to restore a depressed or anxious patient’s sense of self or to strengthen the bond between visitors, staff and patient. The therapist might visit the ICU to play for a semi-conscious patient, or else be called to assist a patient and his or her loved ones in the moment of death. In this article it will be demonstrated how the acoustic guitar’s versatility, mobility, and its spe-
cial musical and cultural attributes make it an ideal instrument to deliver music therapy in such a wide variety of situations.

Furthermore, the importance of Song, be it Rock n’ Roll or Spiritual, in the cancer hospital is discussed, with regard to the acoustic guitar as an exceptionally well-suited instrument for song accompaniment. A case study is presented alongside several case vignettes.

Introduction

By all accounts the psychological pain a cancer patient is facing is considerable and certainly makes the physical agony of the disease and the medical efforts to cure it much harder to bear. A hospitalized patient is traumatized in multiple ways: by the disease for which she is being treated, and by being in a hospital, torn away from her life, work and loved ones. A patient facing this sort of adversity is likely to be a victim of a depressive or anxious mood. In cancer patients, this condition might be exacerbated by a crushing sense of guilt and defeat. Popular belief has it that cancer is something the patient is responsible for, something he brought onto himself by his lifestyle or, more mysteriously, by his general mental disposition. Regardless whether this is a myth or not, music therapy in palliative care is concerned with the mental anguish the disease causes the patient. If he is convinced he caused his own cancer, he might then feel responsible of curing himself as well, by maintaining a positive attitude, by “fighting” the disease; if he is not able to do so, he might experience himself as a failure. In her book ‘The Human Side of Cancer’, psychiatrist Jimmie Holland quotes one of her patients as saying: “I got really depressed when people said I should think positive. I
thought: ‘If that’s what I have to do to survive, I am never going to make it.’” (Holland, 2000, pg. 13).

Music therapy aims at restoring a sense of self to the afflicted person. The context is therapy, and the means is music. Lucanne Magill, who established music therapy at Memorial Sloan-Kettering Cancer Center in 1973, states that the music therapist tries to soothe the suffering by “allowing persons to be where they are in coping with the illness and allowing them to use their defenses for as long as necessary while at the same time encouraging creative expression of thoughts and feelings.” (Magill, 1984, pg. 9).

THE ADVANTAGES OF USING AN ACOUSTIC GUITAR

The acoustic guitar is an ideal musical instrument to deliver music therapy to cancer patients in a hospital setting. Some of its advantages are purely logistical. In a cancer center, the music therapist has to come to the patient, because many times the patients are too weak to get out of bed and go to a music therapy room. An integral part of music therapy in this setting consists also of visiting patients in the hospital’s Intensive Care Unit (ICU).

THE GUITAR IS MOBILE

An acoustic guitar, contrary to the piano, is portable; in a cancer hospital, this is extremely important: a patient’s schedules may vary according to the demands of his treatment. Often he will receive heavy dosages of pain medication, and might be asleep, dozing or daydreaming, when the therapist comes around. Often there is an unannounced visit from family or friends that takes precedence. The music therapist has to be flexible.
and mobile—many times a patient will ask: “Could you come back in half an hour?” With just a guitar and a couple of percussion instruments, the therapist can gladly agree, and try to visit another patient who is on her list.

A music therapist with an acoustic guitar is not obtrusive. Since an acoustic guitar is relatively small and light, the therapist can enter the room of a patient casually, without making a big show indicating that ‘now it’s time for music therapy, let’s be merry!’ (as might be the case if the therapist wheeled a piano into a room). Even an accordion, a violin or an autoharp draws more attention to itself (and, arguably, to the therapeutic purpose of the visit) than a guitar. A guitar seems very much an everyday sight — the important thing is that the patient should never feel pressured or awkward. If she is in a depressed or anxious mood, the last thing she might want is for somebody to come in and “cheer her up” with a song. She should feel absolutely fine about not wanting to hear or play music at any particular time. It’s easier to say ‘no’ to a guitar. It is of major importance for the therapist to “ease himself” into the room — if the patient just wants to talk, fine. If he wants the therapist to leave and come back later, fine. If he wants just one song, fine.

Following David Aldridge, a cancer patient needs an “ecology of treatment at various levels, physical, psychological, social and spiritual” (Aldridge, 2000, pg. 11). Music therapy plays an important role in promoting good social contacts among the caregivers operating at those different levels. Oftentimes, the music therapist will hold a spontaneous mini-concert for the staff — when passing by the nurses’ station with a guitar and obliging to the request ‘Play us a song’. Walking through the hospital corridors with a guitar, ready to play, alters the atmosphere on
the floor considerably. The world of the hospital can become oppressive, obliterating any memory of healthy and happy times. The sound of a guitar in a hospital, even just a faint echo of a few strings being plucked, may serve as a reminder that another world is still possible: a campfire with friends, sitting with a guitar on the beach and singing a song. It is like a single bird singing in a winter forest, invoking the oncoming of spring. This may help to energize patients and staff alike.

The acoustic guitar has an unparalleled dynamic range. Only a drum can be played as loudly and as softly. A drum, however, cannot provide harmony and has a very limited capability for melody, whereas the acoustic guitar is capable of polyphony as well as rhythm. A skilled player can evoke a whole back-up band, guitar, bass and drums. And he can play so softly that the sound of his instrument is audible only when the listener is less than an arm’s length away. On the other hand, the guitar can be loud enough to provide a harmonic structure for dozens of people singing a song at full volume.

The guitarist’s capability to play very softly is especially important in the hospital setting, because many of the rooms in the hospital are designed for double occupancy. There are two beds, divided by a curtain, which means there is very limited privacy for either of the two patients sharing the room. The last thing music therapy should do is worsen the relationship between the patients sharing the room by disturbing a roommate; music therapy might have to take place at extremely low sound levels.

Many times a very welcome effect of music therapy is to put the patient to sleep (especially when the reason for referral is an anxious or overly agitated mood, or pain); guitar music can very naturally “fade out”,

become quieter and quieter until it’s less than a whisper. I have often played in this fashion for a long time, twenty, thirty minutes – when a patient is dozing, or when the patient is in the ICU. Playing softly, singing softly, creates intimacy with the patient. Music transforms the sickroom, and a meditative space can be built where the patient is free to experience his feelings as they arise.

The guitar produces an intimate and therefore nurturing sound. Fingers touch on strings made of steel or (in the case of a classical guitar) nylon, producing a sound wave which is amplified by passing through the wooden “corpus”, or body, of the guitar. A guitar imitates the way a human body produces sound. This natural sound of the guitar makes it more accessible to the human ear.

In all likelihood, all music began with the human voice. Drawing on the example of mother and child, where the voice of the mother becomes the equivalent of bodily contact, Lucanne Magill states that “the human voice is (...) a source for nurturing, for providing the warmth and contact that normally exist between mother and infant. It is an instrument through which we express feelings and thoughts and extend important parts of ourselves.” (Magill, 1984, pg. 7). The music therapist can position himself very close to the patient and play and sing only for him, thereby creating a private space containing only therapist and patient (and privacy is almost impossible to come by in a hospital).

In its frequencies and its capability of polyphony, the guitar is the ideal companion for the human voice. A music therapist can sing and accompany himself on the guitar, singing and playing so softly that it is barely
more than a whisper; yet he is able to play a complete piece of music, regardless of the style.

Many genres of beautiful music such as Brazilian Bossa Nova, Spanish Flamenco, Neapolitan Song, the Blues or the American Folk song, are based on the acoustic guitar. The music therapist, tapping these rich traditions, can instantly evoke powerful images, even if she plays at an extremely low level. Playing a Bossa Nova, for instance, might “transport” the patient for a few precious moments onto a tropical beach; equally, a Jimi Hendrix or Nirvana song can be played, even softly, evoking memories of the patient’s care-free youth. The therapist can draw on a complete liturgy of church music written for the guitar; he can play a classical piece by Bach, or play a devotional composition, using an Indian Raga. Any Beatles song can be played on the guitar, and nobody will miss anything. The music therapist equipped with a guitar can completely trust his intuition and delve into whatever style of music the therapeutic situation warrants. Memorial Sloan-Kettering Cancer Center, being hailed as one of the premier cancer hospitals in the world, attracts a very international population. The music therapist has to be ready to encounter people from all walks of life, from every corner of the world. It might be very soothing for the patient if the music therapist is able to recreate the music of the patient’s place of origin, a Tarantella, a Japanese lullaby, a German folk song. The versatility of the guitar is a crucial advantage.
MUSIC THERAPY AND THE USE OF GUITAR-BASED SONGS

Music therapy in a cancer hospital is really “network therapy”. More often than not, the music therapist entering a room will encounter the patient’s wife, children or parents, his friends, his cousins, colleagues – her network, her community. Nurses, doctors and other staff are an integral part of this network as well. Often, much of the hardship of being hospitalized arises because the patient has to endure the conflict that arises between family members or friends who are committed to the patient’s welfare, but not to each other’s. The music therapist entering the room will have to work through whatever tensions he encounters. Music can bridge the gap between people. A sing-along is ideally suited to release tension, due to the physiological benefits of singing as well as the psychological benefits of singing a familiar, well-liked song and the bonding experience of doing something together. The search for a popular song everyone knows and likes is in itself a pleasurable activity, that might evoke the particular mood, more often than not a joyous one, for which the song is remembered.

Oftentimes a patient will request a particular song the therapist doesn’t know. An example was “David”, a fifty-three-year old man suffering from gastrointestinal cancer.

David asked, among many other songs, for “Bohemian Rhapsody” a very well known but equally complex song by the band Queen. I made a note, and at the next visit, I was able to play the song for him. David (and his wife, who was there constantly) were astonished and happy that I had gone through the trouble learning this rather complex song. I had promised, and delivered. It was a break-through in our relationship. David felt more comfortable opening up to me and telling me how he really felt.
An initial stage in any form of therapy is establishing trust. In the above-mentioned example, the trust was gained by the therapist’s willingness to ‘do the homework’; the patient related better to the therapist because there was evidence that he, the patient, was being heard, was being listened to, was being taken seriously.

The particular song a patient chooses helps the therapist in assessing the patient’s mood and needs. It is a way for an otherwise reserved patient to express his true feelings. Some patients might feel a need to be brave in order not to burden their loved ones. When working with a music therapist, however, they will ask to hear songs that mirror their emotions hidden beneath an outwardly stoic or upbeat surface. Their choice of song alone might be an effective way to release their feelings.

This is well illustrated in an example of a patient named “Richard”, whom I was privileged to work with at Memorial Sloan-Kettering Cancer Center.

Richard was a young husband and father of two sons. His cancer had progressed to the point where there was little or no hope left for him for survival. He never complained, exhibiting stoicism with regard to his pain, while being kind and sincere to everybody on the floor. He never showed how scared and sad he must have felt when it became a certainty that he had to die and leave his apparently very fulfilled and happy life behind. When asked which songs he wanted us to play for him and his wife - who spent every free minute with him - his choice of songs revealed what he seemed to be going through internally. He chose wistful songs, such as Sugar Mountain by Neil Young, which tells of the sadness of leaving one’s youth behind:

You can’t be twenty, on Sugar Mountain,

though you’re thinking that you’re leaving there too soon,
leaving there too soon.

Among other songs he requested were *Only Love Can Break Your Heart*, by Neil Young, and songs by The Eagles, such as *Desperado* or *Love Will Keep Us Alive*. In choosing songs like these he was able to express his sense of loss.

In the case of Richard, who was well-liked by doctors and staff, the nurses and hospital workers formed an important part of his network, his support system. Music therapy helped in strengthening the bond between the patient and the caregivers by drawing the nurses into the therapy session; this was achieved by merely asking them to come into the room and to sing along. A warm and caring patient-nurse relationship is an important factor in the well-being of the patient.

When Richard left the hospital he felt an overwhelming sadness. His nurses and doctors as well as the music therapists had become like a family. When leaving the hospital he had to face the fact that he would probably never see us again. The hospital had become a second home - even if it was a home where he was in pain most of the time.

Richard died at home, his real home, which he shared with his wife and two kids. His relationships with the staff had been so profound that his nurse made a point in attending his Memorial service, which was held in a town several hours outside of New York City.

**THE USE OF SONG AS A RITE OF PASSAGE**

The music therapist working in a cancer hospital is often required to help the patients and their families cope with death. The true meaning and weight of spirituality, of a religious belief - or its absence! - in our lives comes into play when faced with death. Death is the one thing we know for certain will happen, while at the same time the *When?* and the *How?* are never to be known before the fact. In our society it is not customary to remind ourselves that we all will die. It is in religious practice, be it
Catholicism or Zen Buddhism, where we prepare ourselves for the moment of our death. Religion gives us rituals, and rituals are important facilitators of a dignified death. A dignified death means truly honoring the belief that death may be a moment of enlightenment: in dying we might have a glimpse of what our life is really about, a glimpse of the Divine. Preparatory rituals such as prayer, the singing of hymns, the visit of clerical professionals dealing with death everyday – all this will help the dying patient and his family to accept death as “an outcome of living”. (Aldridge, 2000, pg. 12) In the absence of a formal religious practice, songs such as Kumbayah, Amazing Grace or He’s Got the Whole World in His Hands can help a patient connect with her spirituality. Singing a spiritual song, and trying to get everyone in the room to sing along, helps the music therapist create an atmosphere in which the suffering patient and her loved ones can find solace in the belief in God. This may be true also for the many people who don’t believe in any form of a Higher Being. The power of some of these spiritual songs can be experienced by the agnostic as well. A good example is He’s Got the Whole World in His Hands: its verse is designed for the singer(s) to substitute the phrase the Whole World with the names of loved ones. Naming all the friends and the family members is a strong evocation of the strength of a community. It can completely change the atmosphere in the room.

The patient, a woman of about fifty-five years of age, was actively dying. Her family and friends, all in all about a dozen people, had gathered in her hospital room. The music therapist Lucanne Magill, entering the room silently, a guitar slung over her shoulder, started softly playing He’s Got the Whole World in His Hands, until almost everybody joined in. Names of loved ones were sung, and people were crying freely. One family member, an elderly lady, presumably the patient’s mother, sat in a corner, somehow isolated, seemingly unable to open up and share her anguish with the others. Suddenly, in the course of the song,
her name was mentioned, sung by everyone present in the room: “He’s got Grandma in His Hands, He’s got Grandma in His Hands, He’s got Grandma in His Hands, He’s got the Whole World in His Hands…” The woman began to cry as well - finally able to show her sorrow and her need to be consoled.

The song helped the isolated family member connect with the others, to be consoled and to console in return. If the family and the friends come together in such a way, they create a gentle and loving atmosphere in the room. This will support and nurture the dying patient. The music therapist, working with just a guitar, is able to make this intervention spontaneously, when needed, without any preparation.

**PLAYING THE BLUES**

“Fred”, an African-American musician, was terminally ill with cancer; he was not expected to live through the night. His brother was in the room, as was the brother’s son and his spouse, and a few friends. Fred was breathing through an oxygen mask, taking in large gulps of air with pauses of varying lengths between breaths. Everybody in the room seemed to be quite scared and upset, because it was obvious that Fred was really dying. His brother explained that they were both professional musicians, having toured with some of the most famous Blues musicians in the world. I went over to the bed with my guitar, and very softly, I played a Blues song, *Sweet Home Chicago*. I knew only the first verse of the song:

\[
\text{Oh, baby don’t you want to go} \\
\text{Oh, baby don’t you want to go} \\
\text{Back to that same old place} \\
\text{Sweet home Chicago.}
\]

I played this Blues, softly, for a very long time, while the brother and his son as well as some friends joined in with soft humming. Fred himself started singing, lifting his oxygen mask to do so. His
brother told me, with amazement at the coincidence, that their family was, in fact, from Chicago. This was ‘their’ song.

Fred died the next day. The music had provided a strong moment of reminiscence, of re-connecting with the past that helped the patient and his loved ones cope with the crushing reality that the fight was over. The guitar had sustained the Blues, which for long stretches had been just whispered, for almost an hour; this was possible because it was played so softly that it became even softer than the humming of the machines. It blended with all the other sounds in the room, but it changed the atmosphere completely: it became a room itself, a prayer, played over and over and over, an incessant cycle of grieving and coping. This grieving and coping found its expression in the singular twelve-bar form of the Blues, a ‘question’ of four bars (“Baby don’t you want to go?”), repeated twice, concluded by a four-bar resolution, or ‘answer’ (“Back to that same old place, sweet home Chicago”). With the guitar, the music therapist was able to exactly reproduce the song in all its simplicity and hidden complexity: the original recording of this Blues features nothing but the voice and the guitar of Robert Johnson.

The structure and tradition of the Blues is also very inviting to vocal improvisation. Fred’s brother began to sing about Fred, about himself, about the people in the room, about the music therapist. He vocalized imitating the sound of a harmonica. Fred joined the singing from time to time. Because he was so weak, he couldn’t produce much more than a moan, an exclamation here and there, but he was clearly, consciously, taking part in the music. In this fashion, it can be said that the brothers were having their last jam-session together.
The advantages of the acoustic guitar as listed above were crucial in this particular, one-time session: the music therapist equipped with the guitar was able to be unobtrusive - taking up very little space, playing softly, starting with a Blues riff that was barely audible. When it became clear that relatives and friends responded positively, the therapist made the choice to play a bit louder, while still trying to be unobtrusive. The goal, after all, was not to instigate any monumental change, to release anything, to do much. The goal was to accompany and therefore to ease the suffering of the dying man and the people who loved him. The Blues, played on an acoustic guitar, provided a very gentle and supporting structure. There wasn’t any moment where it had to stop, where the Blues had played itself out. It could have gone on through the night.

**THE CASE OF JONATHAN**

Jonathan, a student at Tufts University in Boston, Massachusetts, was twenty years old when the doctor at the Student Health Center, whom Jonathan had seen because of headaches, diagnosed him with Leukemia. Immensely creative and intelligent, Jonathan was a very special young man, much loved by his family and friends. I liked him immediately; he was sweet and funny, but also fiercely sincere. He shared this virtue with his brother Josh, who is eight years older. Josh was very devoted to his younger brother’s care and spent many hours at Jonathan’s bedside. The brothers made a great pair, they had a very dry, no-nonsense New York wit about them that was thoroughly engaging. Josh was deeply involved in Jonathan’s musical life. Jonathan was the lead singer of a garage rock band, *Johnny Physical and the Physicals* (http://www.johnnymusical.com), playing venues in Boston.
Jonathan was also a big fan of Buddy Holly and Johnny Cash. All of his favorite music was guitar-driven. Josh at this stage functioned as a collector, organizer and distributor of Jonathan’s music. He often gave me tapes of Jonathan’s concerts. On the brother’s request, I turned these tapes - as well as the recordings I did with Jonathan at his bedside - into CD’s, using the equipment of my home studio. This helped to give our sessions together an even more ‘professional’ air, and, as a music therapist, it firmly established me as a committed supporter of Jonathan.

I first saw Jonathan in March 2002. He had just suffered his second relapse of leukemia and was undergoing another round of intense chemotherapy. Over the course of our work together, Jonathan was growing increasingly weak. He had a fungal infection in his lungs and a whole host of minor but bothersome ailments. At our first session together, which Josh videotaped, I quickly realized that Jonathan wasn’t going to enjoy religious songs or any of the soft Brazilian music I often play. He needed the music that he loved, a masculine, assertive kind of music, he needed Rock n’ Roll - a style relying almost exclusively on the electric guitar. In popular culture, this sound stands for a sort of rebellion against the establishment. As a symbol, it was established in the fifties and sixties, but now it seems rather timeless: from The Rolling Stones to Marilyn Manson, Rock n’ Roll music seems to channel anger and frustration.

1. Jonathan, as Johnny Physical, was famous for his outrageous stage antics worthy of an Iggy Pop. An anecdote told to me by his father involved his brother Josh visiting a concert of The Physicals. Jonathan’s father told me how embarrassed Josh, who had gone to the show with a date, had been by his brother’s especially wild performance that evening. “He even did a thing called ‘stage-diving’”, Jonathan’s father told me. (‘stage-diving’ describes a performer jumping from the stage into the audience, head-on, confident that the spectators will support him or her with their hands) Later on, when talking to Jonathan’s brother Josh, I remembered the story and asked him about it. “Yeah,” said Josh, “Jonathan was wild that night. He stage-dived.” “But why would this be embarrassing to you? Isn’t this a routine part of a rock concert?” “That’s true,” said Josh. “But they were playing in a coffee shop …”
as well as vitality and exuberance. For many people, it is the soundtrack of their own coming of age, capable of triggering powerful memories of health and vigor. The guitar, being the main instrument in virtually all of Rock n’ Roll, is a symbol for feeling young, free and assertive. This is a precious and nurturing way to feel for most patients in a cancer hospital, who, through the disease and the efforts to cure might have lost their sense of self, their autonomy. There is something tough, vital and indestructible, at least in spirit, in a Rock n’ Roll song. I believe that this is a “healing feeling”.

EXPRESSING PAIN AND SORROW

Rock n’ Roll gives voice to feelings that are universally experienced but expressed only in a veiled form in other styles of popular music. Anger, rage, confusion, bitterness or depression are often channeled in Rock n’ Roll songs. Jonathan’s song choices reflected his sometimes very depressed mood in the hospital. It may be well summed up in the refrain of *Venus in Furs*, by the sixties’ band “Velvet Underground”, a song he liked and which we recorded: *(click here for listening MP3)*

> I am tired, I am weary,  
> I could sleep, for a thousand years  
> A thousand dreams could not awake me...

A music therapist playing guitar is able to connect with patients who need Rock n’ Roll music’s honesty. It’s guitar music. It’s difficult to play a Rock n’ Roll song on the piano or on an accordion and retain its feeling. This is why the guitar was of crucial importance to Jonathan’s music therapy.

THE MUSIC THERAPY AS GOAL-ORIENTED MUSIC MAKING.

Jonathan’s brother made the following statement about the music therapy process:
“From the beginning, Alessandro felt more like a friend than a therapist, their time together felt more like ‘hanging out’ than therapy. I don’t think it really occurred to any of us, except in hindsight perhaps, that what they were doing together was music therapy. I mean, in the back of our minds we realized that this was Alessandro’s job, but during the time they spent together the focus was less on Jonathan’s ‘condition’ than the making of the music. (…) First, they would choose a song to play, then Alessandro would learn it on the guitar, then they would record it together on mini-disc. Their recording sessions were full of laughter but were also intensely serious. When the disc player was running, Jonathan wasn’t in a hospital, he was in a recording studio; he wasn’t infirm, he was full of health and vigor. He wasn’t unfree, he was free.”

Due to Jonathan’s dedication to creating quality recordings, the music therapy took place in an atmosphere of almost professional focus and concentration. Tape was rolling, both Josh’s video camera and my mini-disc recorder. On that first meeting, Jonathan showed me a few songs by Johnny Cash and Buddy Holly. He had sheet music with the lyrics and chords, but since I was unfamiliar with these songs, Jonathan taught me the guitar parts. He took the guitar and attempted to play them for me, which was very difficult since his fingertips were too tender, a side effect of the chemotherapy. So he sang the parts to me, and it worked. The recordings are startlingly intimate; Jonathan’s voice, on this first session, is still firm, even though it is apparent that he is sick. There is vigor and devotion in his singing. Over the course of a few months, Jonathan and I recorded a whole CD of material.

click here to listen to Jonathan and Alessandro

Johnny Cash: Folsome Prison MP3

Johnny Cash: I guess MP3
Our work together helped Jonathan to experience a sense of mastery and control, which he had been slowly losing during the course of his disease.

Sadly, Jonathan was growing weaker and weaker, and this is documented in the music we recorded together.

In the end, all he could do was whisper the lyrics. As Jonathan was losing his battle against both the cancer and the fungal infection of his lungs, we couldn’t do our sessions anymore, and the focus of the music therapy shifted. I would play for him while he was sleeping or dozing. At this late stage in the course of Jonathan’s illness, the family’s needs became more prominent. My role was more that of a therapist to Jonathan’s family than a music therapist for Jonathan. His parents were basically living in his hospital room, and they were in deep despair. During my visits to Jonathan, I would spend more and more time talking and listening to them. I believe that all three, mother, father and brother, felt a terrible, albeit irrational, sense of guilt for the youngest family member’s deadly disease. I felt that they trusted me – a trust evidenced in the following example: Jonathan would record long diary-type entries by speaking into a small cassette recorder, freely voicing his innermost feelings about himself and his family and friends. Josh asked me to transfer this spoken diary to CD’s. I was glad to do it; I was honored that both Josh and Jonathan trusted me to the extent of sharing these private things.

Jonathan died in the summer. Josh built a web site devoted to his brother, where he collected articles and comments of friends and family.
Jonathan’s nurse wrote a piece about him as well. In the future, Josh plans to make a documentary film out of all the video footage he has of Jonathan.

THE GIFT OF WORK

Goal-oriented musical practice is a powerful tool in music therapy: there are few activities as rewarding as working on a musical piece and “getting it right”. Music is equally generous as it is honest. If you don’t put anything into it, it is not going to give you anything back. Music therapy is a means to restore the vitality in a patient, by making him work. Work may be the supreme therapy, in allowing the patient to do something useful, to experience himself as competent.

In Jonathan’s case this was even more pronounced because he was a musician and bandleader. The weekly music therapy sessions were precious to him for he could completely enter a world where he was in charge, where he knew exactly what he was doing. For once, he was in control again. His brother Josh wrote:

“He felt that this [the music therapy] was a real collaboration, an extension of the musical journey that was his life, not an interruption from it. Jonathan didn’t crave distractions from life, he craved the raw experiences of life itself. That’s what [the music therapy] gave him— the ability to transform hospital time into human time. Hence, there is nothing bittersweet about listening to the music they recorded together. It is incredibly powerful, incredibly uplifting, and incredibly rock n’ roll.”

In conclusion, the acoustic guitar - due to its versatility, mobility, its special musical qualities and cultural attributes - is an ideal choice as the main instrument for music therapy delivery in a cancer hospital. The music therapist with a guitar can freely move about the hospital, adjusting to the unpredictability of hospital routine and the multifaceted needs of patients and their families.
It seems appropriate to close with the words of a patient who was lying in a semi-conscious state in the ICU when he was visited by the music therapist:

“The first thing I responded to in the ICU was this sound [the sound of an acoustic guitar the music therapist was playing for him]. It rang out like in a cathedral. I was looking forward to your visits so much. It took me to this place where things were ok.”

References


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Essential Guitar Skill Development Considerations for the Contemporary Music Therapist

Robert E. Krout

Abstract

This article considers some guitar skills which might be considered “essential” for the contemporary music therapist. After some overall observations, 10 such essential areas are briefly outlined and described. Sample recommendations for clinician development are made in each area. They include a knowledge of open chords in various different positions for voice leading, barre chords, interesting strumming patterns with rhythmic emphasis, varied fingerpicking patterns, major and minor pentatonic scales for improvising, familiarity with guitars of various types (steel-string, classical, electric), blues/rock/jazz chord extensions and progressions, use of right (strum) hand rhythms, use of non-chord tones, and chord embellishments/left (chording) hand techniques. An emphasis is placed on the continuing guitar skill development of the clinician.
Introduction

The guitar continues to be a mainstay for music therapists in their work with clients demonstrating a wide variety of needs, abilities, and interests (Kennedy, 2001). The versatility, portability, and musical integrity of the guitar allows clinicians to adapt its uses to music of a wide variety of styles. Music therapists are becoming ever more adventurous in how they use guitar. New ways to use the guitar in clinical work, research, songwriting, and music therapy education/training are increasingly shared through the music therapy literature and at professional conferences and workshops. Unfortunately, university music therapy training programs do not usually allow for in-depth student guitar study due to course and programme credit limitations. Unless a student’s primary instrument is the guitar, they may only receive one or two semester’s worth of instruction. In addition, the nature of the guitar instruction may focus on only one style, such as classical or folk. It has been suggested that a more in-depth study of guitar could be beneficial in university music therapy programs (Kennedy, 2001). Many internship settings also provide some continued guitar skill development as part of their training. In addition, clinicians may work on expanding their guitar skills throughout their career. This may especially true when beginning work with a new client population motivated by more contemporary or different music than the clinician is used to playing on guitar.

Essential Skills

If continued and more developed study is pursued by the music therapist, are there "essential" contemporary skills to be learned for application in clinical settings? While the "essentiality" of a skill will be in part deter-
mined by the needs and interests of clients with whom the therapist works, there are some skills that every music therapist can develop as part of their guitar abilities and playing resources. Ten such skill areas will be briefly considered here. Selecting ten areas was a challenge, as this number could easily be doubled. In addition, an entire article (or book) could be devoted to each skill area. The observations below do not represent a complete and exhaustive exploration of these skill topics. Rather, they are intended to stimulate the thinking of clinicians and perhaps add some extra motivation and ideas towards continuing to develop guitar skills that enhance the ultimate music-based clinical experience for therapist and client. Sample resources are also listed for the reader at the conclusion of the article. It should be noted that the below examples are described form a “right-hander’s” point of view, with the left hand finger- ing the frets and the right hand sounding the strings. Theis perspective can easily be reversed for those who are left-hand dominant.

**OPEN CHORDS**

The first skill area is a knowledge of open chords in various different positions. This is essential for musical interest and to allow for voice leading. So often, clinicians use open chords (chords which use open strings) in first position, limiting their chording hand to the first four frets of the fingerboard. The chord positions learned during beginning study remain the positions used in every song after that. The root of each chord is often played as the bass note of both major and minor chords, including seventh and other extended chords (e.g. E major chord sounded from the sixth string, A major chord from the fifth string, C major chord from the fifth string, d minor chord from the fourth string, etc.). In essence, every chord is thus being played in root position. The bass movement from chord to chord is thus stilted and chord progressions can sound extremely disjointed. Most clinicians would never consider doing this
(playing all chords in root position) at the piano. Open guitar chords can also be fingered and/or sounded as inversions so that the third or fifth can feature as the bass note. Bass notes can then be selected by how those notes function in the chord progression as chords lead from one to another. For example, the simple progression of C major - G major - a minor sounds rather like a stick figure if all root notes are sounded in the bass. Simply sounding the G chord from the fifth string instead of the sixth string produces the bass note B, or the third of the G chord. The bass note progression now sounds as C (root of C chord) to B (third of G chord) to A (root of a minor chord), thus connecting the chords through the bass notes. In a “fake book”, we might see this fingerling of the G chord noted as "G/B". It is simply Other open chords can be fingered in new ways as well. For instance, when fingerling an open D Major chord, an option is to wrap the thumb of the chording hand around the neck to fret the sixth string at the second fret (your guitar class teacher probably wouldn’t have liked that). This produces a first inversion D Major triad (F# in the bass). If this chord is played between G major and e minor (i.e. G Major - D/F# - e minor), the bass movement again connects the three chords. There are many other possibilities when moving from chord to chord if the bass notes are considered and fingered/sounded accordingly.

BARRE CHORDS

The second consideration is the ability to construct and play (not just finger, but sound) barre chords. If a therapist has had only one semester of guitar training, barre chords may seem like only a distant land of sonic possibilities. However, not knowing how to use barre chords severely limit’s the available chordal possibilities. The inability to finger frequently-used major and minor barre chords may actually restrict the therapist from using songs which are motivating to the client. They may avoid selecting songs or progressions which require these chords. Many
clinicians learn “easy” versions of what should be full barre chords. A common example is the B Flat Major chord played with four fingers and fingered from the fourth string third fret (in essence an A Major triad moved up a fret with an F note added on the first string). These fingerings often result in a less than satisfying bass sound. For instance, fingerling and sounding that B Flat chord from the fourth string as described above results in a second inversion triad (F in the bass). Unless this chord is being played as a second inversion triad for a reason (e.g. in a progression), it may sound awkward, out of place, and musically weak. The theory behind how barre chords work and how to successfully finger them is relatively simple and certainly worth exploration (see Krout, 1994). For example, power chords can serve as a bridge to full barre chords, providing convincing bass sound and success for therapist and client.

**STRUMMING PATTERNS**

Our third skill area is strumming patterns. So often we use what is familiar to us in our guitar playing. There seem to be certain, almost predictable strums that clinicians use. Clinicians usually begin by learning basic quarter and eighth note down-up strumming patterns that sound on even divisions of the beat/pulse. With continued study, a basic syncopated strum in 4 is often learned. This quarter - eighth - quarter - eighth - eighth - eighth pattern is usually strummed as down - down - up - up - down - up. While this pattern does give some forward motion and lift due to the syncopation, it becomes worn out when used in song after song. In triple time, clinicians often sue a simple quarter - eighth - eighth - eighth - eighth pattern, played with down down-up down-up strums. This can also become musically tiring to both the client and the therapist. There are many things we can do to make our strumming more interesting. One basic change is to varying strumming patterns between songs. If there are four songs in the same meter, use a different strum pattern for each song.
Longer songs can also be played with two or three different patterns. One strum pattern can be used for the beginning sections, another (perhaps more active/complicated) for the middle, and a third (again more intricate) for the final sections. Often, songs that are simpler in terms of number/quality of chords and progressions can benefit from more interesting strumming patterns. Likewise, when a strophic song has more than several verses, varying strum patterns can keep listener interest. There are many possible strum patterns for songs in simple meters as well as irregular meters. In addition to the actual beat and sub-beat nature of the strums, rhythmic emphasis can also be varied. We are used to accenting the strong beats of a measure in Western music. Off-beats (e.g. Reggae rhythms) can also be accented, as can subdivisions of a beat (e.g. funk rhythms). Possibilities are endless. The main point is to select strum patterns that capture the feeling of the song and maintains the listener’s (client and therapist) attention and interest.

The fourth skill area and consideration is using varied fingerpicking patterns. Often times clinicians use fingerpicking when guitar volume is not such an issue and the guitar can be used in an intimate way. However, therapists frequently use limited picking patterns utilizing only the thumb and index or middle finger of the picking hand. In addition, the patterns themselves are repetitious and decline in musical interest during and between songs. Those trained in classical guitar often know varied patterns, but may not be able to transfer them from their learned repertoire to accompanying songs in varied styles. The key is to use patterns that enhance the musical feel of the song and allow for the accompaniment to facilitate the clinical reason(s) that the song is being used. Fingerstyle guitar instruction books (see resources at end of article) can provide a wealth of resources and possibilities for the clinician.
**PENTATONIC SCALES**

The fifth area we will look at briefly is using major and minor pentatonic scales for improvising. Music therapists often make use of pentatonic scales with pitched percussion instruments and piano. However, they are often not utilized on guitar due the therapist’s lack of familiarity in transferring them to that instrument. However, adapting pentatonic scales to guitar is not difficult, as the scales can be played with one (in the case of open positions such as G Major and e minor) or two fingers. With pentatonic scales, melodic improvisation by the client can be facilitated and musically supported by the therapist on guitar, piano, or another instrument. In addition, the therapist may themselves use pentatonic scales to improvise with the client playing guitar or another instrument/singing. Pentatonic are ideal for beginning blues work as well, with minor pentatonics used over a backdrop of I - IV - V7 progressions. Major pentatonics can also be used to achieve country and southern (U.S.) rock sounds. See Krout (1994) for some pentatonic ideas.

**VARIOUS GUITARS**

The sixth area in our guitar quest is familiarity with guitars of various types, including steel-string, classical, and electric. So often the music therapist uses only one kind of guitar. In addition, that guitar may not be musically appropriate for the style of music being played (e.g. a classical guitar being used with rock music). Clinicians may be limited by the availability of instruments in their clinical setting/facility, which may unavoidable. However, the music therapist should feel comfortable using classical, steel string, and electric guitar. Some experienced clinicians have never used a flat pick, while others are used to strumming a classical guitar with a flat pick. Many therapists have never played an electric guitar. The result is that they may shy away from using this resource, even when it is available and the client is motivated by it. There are certain guitar techniques such as string bending that are also used music
more with electric guitar that with steel string or classical models. I am not suggesting that all clinicians be equally skilled with all three basic types of guitar. However, if the music that motivates their clients is best played on a certain type of guitar (classical, steel string or electric), then it is the therapist’s responsibility to become familiar with that instrument. It may be intimidating at first (especially when approaching the electric guitar for the first time), but the musical and clinical rewards will be worth the effort!

Seventh is familiarity and flexibility with common blues/rock/jazz chords and progressions. We have already briefly considered open chords and barre chords. Blues/rock/jazz chords are also essential in interpreting popular music from the 1950’s onward. While clinicians would know to add a lowered 7th to a major chord to give it a “bluesy” feel, there are many more possibilities. These include chord extensions such as 9ths, 11ths, and 13ths. All three of these also imply a lowered 7th, but add tones that would normally function as non-chord tones (e.g. suspensions) in traditional Western music. These chord extensions can be realized over minor triads as well, and minor blues and jazz feels can provide new opportunities for improvisation. Major 7ths are also commonly heard in jazz, and can be added to any major chord, as well as be used above a minor chord for tension and interest. Chord progressions from jazz, blues, and rock also offer limitless possibilities for music structures. While a 12-bar blues will be familiar to clinicians, there are many variants of such progressions. In addition, there can be 8-bar and 16-bar blues forms as well (and others). Rock often features progressions not found in traditional harmony and style. For instance, progressions which use major chords built on the lowered third and lowered seventh scale
degrees in a major key have been used a number of times in “hit” songs. Other familiar rock progressions use elements of traditional harmony in new way, such as many Beatles songs. Think of the opening chords of Nirvana’s “Smells Like Teen Spirit”. What you hear is two sets of V - I chords (traditional resolution) a minor 3rd apart (following chords not in original Major key of F). The progression features an F chord resolving to a B Flat chord followed by an A Flat chord resolving to a D Flat chord. Jazz (with so many styles within the overall art form) also offers almost limitless progression options, possibly starting with the very familiar II7 - V7 - I sound.

**STRUMMING**

Our eighth area also involves strumming. While we have looked at strumming in general, the use of right (i.e. strum) hand rhythms allows the clinician to add a rhythmic and percussive feature to his/her playing. Specific techniques can include slapping the strings with the strumming hand during strumming patterns. One can also use the fingers of the strumming hand to hit and slap the guitar body, top (face), and other parts of the instrument in-between strums to add percussive emphasis. Even hitting the open strings (over the sound hole or treble end of the fingerboard) can add interest. The late guitarist Michael Hedges was one acoustic guitarist who used these techniques to great effect. If not using the left (chording) hand to finger the fretboard, both hands can be used to percussive effect on the strings or guitar body/face. Of course, care must be taken so as not to damage the instrument!

**NON-CHORD TONES**

Ninth in our list is the use of non-chord tones. In traditional Western music, we are often used to non-triad chord tones such as 2nds, 4ths, 6ths, etc. as used as passing tones, neighbour tones, and in other types of resolutions (to a triad). Popular music and jazz have featured non-triad tones
as members of “stable”, non-resolving chords for many years (e.g. the closing chord of the Beatle’s “She Loves You” features a Major or added 6th. Music therapy styles and approaches such as Nordoff and Robbins also make use of non-chord tones to add musical interest (Nordoff & Robbine, 1983). These concepts can, and have been adapted and transferred to guitar (Aigen, 2001). However, many music therapists simply have not been taught chords that include these tones. There are available guitar chord dictionaries which can serve as valuable resources in learning new chords, especially those that add musical interest to the mix. One can also learn new chords from “fake” books of various styles, especially popular music from the 1960’s onwards.

Our tenth area is chord and melodic embellishments using left (chording) hand techniques. These techniques include hammer-ons, pull-offs, slides, bends, and blends (playing two or more strings simultaneously and bending one string while keeping another at fingered or open pitch). Hammer-ons, pull-offs, and slides can be used on any type of guitar (classical, steel-string, or electric). The bends and blends are easiest to do on an electric guitar. They can also be performed with relative ease on the treble E and B strings of a steel string guitar. However, bending and blending are difficult on a classical guitar due to the composition of the strings. Hammer-ons and pull-offs add melodic interest and variety, especially when a chord is played for several (or more) consecutive measures/bars. The slides, bends, and blends allow you to sound the pitches “in-between” the half-steps. This is especially useful in blues/rock/jazz songs and styles.
Conclusion

We have come to the end of our “top ten” list, but certainly not to the end of the possibilities for continued guitar development. Guitar learning, as so much about music, is a life-long journey for the music therapist. As we grow as musicians/guitarists, we grow as clinicians as well. I wish you pleasant riffs along that journey!

References and Resources


Robert Krout, Ed,D, MT-BC, RMTh
MusicTherapyProgrammeLeader MasseyUniversity–NewZealand
R.E.Krout@massey.ac.nz

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Introduction

On many occasions, the late great Andres Segovia described the guitar as, “a small orchestra unto itself” (Segovia, personal communication, 1976). Over the years, I have learned the profound nature of Segovia’s statement, first while using the guitar as a primary instrument in clinical music therapy, and later by teaching guitar skills to music therapy students in group and individual lessons. The guitar is a naturally indigenous tool of music therapy in the hands of a therapist with good musical skills and greatly enhances the opportunity to reach clients on an intimate and in-depth therapeutic level (Kennedy, 1998).

The tonal quality of the guitar and the direct nature with which it is played are qualities that make its use in music therapy unique to other instruments. The guitar’s capacity to produce chords and an extensive melodic range allows the music therapist to provide vocal and instrumental accompaniment, use the guitar as a solo instrument, and incorporate
advanced techniques such as rhythmic tambora effects and artificial harmonics which may be played as melodies.

1. Tuning

Tuning the guitar is an art, especially when using a guitar with nylon strings. Music therapy students should learn to tune the guitar using several methods including the use of a pitch pipe and the piano as pitch references for the open string pitches. Once the guitar is roughly in tune, fine tuning methods may include using one string as the reference point and tuning the other five strings to that string i.e., octave tuning. This is more effective than using the fifth fret method because inaccuracy results when conveying the reference point from one string to another. Typically, I use “A,” the open 5th string, as a reference point and then use octaves to tune the other strings to pitches produced on the 5th string. A second step to perfect the fine tuning method includes cross-tuning the strings using harmonics i.e, lightly touching a string without pressing it to the fingerboard at designated frets, producing the “chime” sound, and comparing the reference string harmonic to another harmonic of the same pitch. For instance, compare the harmonic of the 5th string at the seventh fret (reference point) to the 6th string at the fifth fret. Using harmonics to fine tune allows hearing of the “wavering” or beats between pitches. When the out of tune string is adjusted until the beats “flatten out” or dissipate the guitar is REALLY IN TUNE.
2. Learning chords

Teaching chords by visual shapes as well as root, third and fifth sounds may enable some students to accomplish memorizing chords with less difficulty i.e., the D major chord is an upside down triangle. I also instruct students to “mezmerize” chords, which is defined by “changing chords with no hesitation,” so that chords become kinesthetic memory. Students will first place individual fingers separately on the fretboard but may quickly acquire the placement of fingers in groups of twos and threes until all fingers are placed simultaneously as a unit. The ease with which the instructor imparts such skills is key to the rate of the students’ acquisition. I usually attempt to infuse the “mesmerizing” concept with a bit of humor in an effort to move students through the drudgery of learning chords. The “quick draw” method, is a fledgling imitation of a John Waynesque cowboy character with the following script; “Well partner, when you can draw your left hand from the holster three times and nail the chord- its mezmerized!”

2.1 Strumming Techniques

The typical up and down strumming technique adapts to most songs and may expedite students’ execution of syncopated rhythm patterns while simultaneously changing chords. The next step in learning to strum is the “boom chuck” method which is simply playing the bass note of a chord and strumming the rest of the strings belonging to the chord in a single downward stroke. This technique is indigenous to many Country/Western, folk songs and used in modified versions of rock songs as well.

2.2 Fingerpicking Techniques

Fingerpicking is a more difficult technique than strumming and is conveyed easily by the use of tablature. I find that even though music students are capable of learning to read guitar music, learning fingerpicking techniques via non-music reading strategies is easier for students to
assimilate. I use the typical classical guitar designations for right hand fingers: p=thumb, i= index, m= middle, a= third finger (ring finger) on a six line horizontal staff. Each line from the top to the bottom represents the 6th through the 1st string.

Using bass runs as “passing tones” between chords provides novelty and interest to songs and may benefit music therapy clients by providing predictable cues to musical stimuli. When the guitar is used as an accompaniment instrument for rhythm bands, melodic instruments, group singing, or movement to music activities, bass note runs may provide clients with auditory signals to vary their instrumental performance or to execute a variety of physical movements in movement to music activities (Thaut, 1990). Additionally, the use of tablature with horizontal lines representing the strings and numbers indicating designated frets or open strings for individual notes may expedite the music therapy student’s acquisition of guitar skills in the context of learning music therapy clinical skills.

2.3.1 Use a strap on your guitar. Using a strap allows the therapist to take advantage of the portable nature of the guitar and to bring therapy to clients in confined and otherwise inaccessible healthcare settings. Whether standing by a patient’s bed or moving in closer proximity to clients during group singing to enhancing eye contact, the ability to move while playing the guitar may foster a person centered type of interaction. As Sanford and Rogers so eloquently stated (1985), “being immediately present and accessible to clients relies on moment-to-moment experience in each relationship” (p.136).
### 3. Bar chords

Four bar chord forms are essential to the music therapist’s proficiency on the guitar. The six-string major and minor forms and the five-string major and minor forms will allow the therapist to provide block chord accompaniment by producing all the diatonic chords (with the exception of the vii chord) in all 12 keys without using a capo. Many students experience anxiety when attempting bar chords for the first time. I attempt to dispel this fear by tackling bar chords early in the semester and teaching approximations or “mini-versions” of the full bar chords i.e., the four string F chord. Isolating the barre itself and accomplishing a clear, undistorted, “no buzzes” sound for each string in the barre form before adding the additional fingers or using the full five or six-string rendition of a bar chord may be advantageous as well.

### 4. Using the capo and transposing songs

Therapists should possess the ability to transpose songs on the guitar with and without a capo. Questions on the American Music Therapy Board-Certification Exam require therapists to problem solve transpositions with questions such as: Using the C chord form as the I chord, upon which fret do you place the capo when transposing a song to the key of Eb? This skill requires the therapist to know that the capo is placed on the 3rd fret in order to use the C chord on the 6th fret to produce an Eb chord. Functional use of the capo allows the therapist to use familiar chord forms to play in difficult keys on the guitar. Functional use of the capo is a necessary technique in order to play in keys that are comfortable for clients’ singing ranges.
FIGURE 1. The percentages of academic music therapy programs including guitar proficiency skills

5. Hierarchy of guitar skills

Many of the skills mentioned in this article were derived from a survey of guitar skills and proficiency lists cited by directors of college music therapy programs in the United States. The importance of guitar skills and many views concerning clinical uses of the guitar were evidenced by the participants in this survey. For example, several directors rated the guitar as an important instrument in music therapy because of its port
bility and versatility. Respondents also rated the guitar equally important to the piano in the clinical success of music therapy and noted that many facilities do not have pianos.

Many college degree programs are currently extending their course offerings for study of the guitar which may allow students to progress beyond the minimum requirements of guitar proficiency. Part of the rationale for extended study may include acquisition of skills at the bottom of the hierarchy such as improvisation. Many of the directors commented on the utility of improvisation skills in music therapy even though most participants acknowledged the difficulty in acquiring such skills. The words of one director best summarizes the importance of improvisational skills.

“In the undergraduate area there is much to be accomplished. One area is competency in presenting the self, musically and socially. Students should perform well, so clients and therapists become connected through musical/personal communication. Improvisation is important, and study may begin in undergraduate education, but the ability to improvise requires exceptional talent and much personal confidence as a performer” (Kennedy, 2001, pg. 133).

References


Kennedy, R. (1998). The effects of musical performance, rationale emotive therapy, and vicarious experience in the self-efficacy and self-


**Biography**

Roy Kennedy is currently the Director of Music Therapy at The University of Georgia where he teaches the core courses in music therapy, supervises music therapy clinicals, conducts music therapy and music education research and teaches a Music for Exceptional Children class for therapists and music educators. He holds the Ph.D. in Music Education with an emphasis in music therapy from the University of Kansas, a Master’s Degree in Music Education from East Carolina University and a Bachelor’s of Music from The University of North Carolina at Greensboro. Roy’s specialty within the music therapy discipline is using music performance techniques and cognitive strategies with juvenile delinquents and disadvantaged children. Other research interests include piano techniques used in music therapy for autistic children and the inclusion of guitar programs in public school music education curricula.


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The instrument allows you to speak through it - Interview with jazz guitarist Steve Abshire

by Petra Kern

Introduction
Hearing fabulous musicians at the East Coast Jazz Festival 2003 in Washington D.C., made me realize again and marvel at how much music connects people coming from different places, lives and backgrounds. Music becomes the universal language, fills the room with energy, touches our souls, and lets us experience unity, joy and peace. A master of creating these moments is jazz guitarist Steve Abshire. In his music you can hear the joy and excitement and feel the connection between him, other musicians, and the audience. He says: "Music is something to share with others." Steve shares not only by performing, but also by giving Master Classes in guitar and rhythm section technique in schools and university programs. I had the chance to hear Steve again at the Elon University Jazz Festival 2003 together with trombonist John Jensen (http://www.dcjazz.com/johnjensen/), vibraphonist Jon Metzger (Director of Jazz Studies, Elon University, NC, USA: http://www.elon.edu/jazz/) and students of the Elon University Jazz Band. The performing artists intention was to give students enrolled in the jazz studies program as well as students from school bands in the area a chance to learn and experience jazz music first hand. As a "Grande finale" the students and artists performed together for the community. I talked to Steve after the concert about his experiences and insights. During the interview, he refers to the jazz festival participants, trombonist John Jensen, and vibraphonist Jon Metzger several times. The music excerpts are live recordings from the festival's concert and a generous gift to us from wonderful musicians.

The Interview

When you improvise and play with others, I can hear and feel the joy, excitement and connection between you and the other musicians. What is it that connects you with other musicians?

ABSHIRE TALK PART 1 (1.569 KB)
ABSHIRE MUSIC PART 1 (910 KB)

What role does your audience play?

ABSHIRE TALK PART 2 (802 KB)
ABSHIRE MUSIC PART 2 (661 KB)

Are there other variables which have an impact on connecting with one another?
After working with the students participating at the Elon University Jazz Festival the last two days, do you have the feeling that you can teach this level of connection?

What is special about the guitar? What qualities does this instrument have and what makes it different from other instruments?

When you play your guitar, do you feel like you can express yourself, especially through improvisations?

When we talk about touching the soul, I think there is a close connection to healing. Have you ever played for people with health issues? Do you have any experiences with that?
We definitely enjoyed the performance tonight. You could see the peoples faces light up and the energy take hold of the concert hall. Thanks for taking us to this other place tonight. My very special thanks to you Steve for sharing your experiences and insights with me and our Music Therapy Today readers.

ABSHIRE MUSIC PART 6 (412 KB)

PetraKern@prodigy.net

Want to know more about Steve?

Steve Abshire is a jazz guitarist, teacher, and clinician in the Washington D.C./Baltimore area. Steve's mainstream style comes from years of study with Herb Ellis, Barney Kessel, Joe Pass and rhythm guitarist Steve Jordan. He has appeared in concert with notable jazz greats, Herb Ellis, Gene Bertoncini, Milt Hinton, Tal Farlow, Keter Betts, Scott Hamilton, Frank Vignola and Marian McPartland, to name a few. He also has accompanied many legendary vocalists such as Della Reese, Rosemary Clooney, Joe Williams, Ernie Andrews, and Etta Jones. Steve has also appeared in concert with the "Great Guitars" as a substitute for Barney Kessel. Twice Steve went to Europe to perform at the famed "Jazz In Marciac" jazz festival held in Marciac, France. In 1997, Steve retired from the U.S. Navy Band's Commodores, where he performed as guitarist/featured soloist for 18 of the 24 years he spent in Navy Bands. He was on faculty at the Levine School of Music in Washington, D.C., for five years, and is presently on faculty at Cedar Brook Academy in Clarksburg, Maryland, as well as teaching privately. As a clinician, Steve has given Master Classes in guitar and rhythm section technique at the Armed Forces School of Music, James Madison University, Elon University, and various other local colleges and high schools. Steve can be found on numerous recordings, including 2 of his own. His first, "Big Brass Bed Blues" received a 4 1/2-star rating from Down Beat Magazine. His latest release is "Come In From The Rain". This recording, along with appearance calendar and other information, is available at his Web site at www.steveabshire.com.

MUSIC THERAPY MASTERS PROGRAMME

Department of Music
FIN 40014
University of Jyväskylä
Tel: +358 14 2601 330
Fax: +358 14 2601 331

Music therapy staff and contact information
Esa Ala-Ruona (Assistant) esaala@cc.jyu.fi
Jaakko Erkkilä (Professor) jerkkila@cc.jyu.fi
www.jyu.fi/~jerkkila/musiikkiterapia/
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Department of Music
The department is a part of the faculty of humanities. At the department of music we have three disciplines: musicology, music education and music therapy. The name of the department was “department of musicology” until August 2002 when we decided to change the name. The current name covers better the divergent subjects and acts going on under the head title ‘music’. As far as we know it is still unusual to have that kind of combination of music disciplines on academic level.

The department was established in 1968 with musicology. In 1982 the unit of music education was established, and finally in 1984 music therapy, first as so called completion education. Initially we did not have any permanent positions in music therapy but the education was carried out as additional teaching by the music therapy experts in addition to the lectures given by the staff of musicology and music education. In 1997, music therapy got its first full-time position.

Music therapy, as the smallest discipline at the department, has derived much advantage from collaboration with the two other disciplines. This can be seen as synergy benefits at least on the areas of education, supervision and research. The collaboration has been mutual as well. Many of the musicology and music education students have participated in music therapy lectures as well as made their tests, even Masters thesis, from the point of view of music therapy. Currently we have even funded a research project based on inter-disciplinary collaboration.
Clinical studies in Jyväskylä

From 1984 to 1997 the form of the music therapy programme was a three years’ clinical training. In 1997 we gave up the clinical training and did establish the Masters programme. However, it is still possible to get clinical training in Jyväskylä, not through a University but through an institute called Eino Roiha (named after a musicologist, music psychologist, composer and musician who worked in Jyväskylä for many years before the World War II). University is one of the owners of the institute and in close collaboration with it.

The birth of the Masters programme

In 1980’s we had only two organisations in whole country with music therapy clinical training, the other one (in addition to University of Jyväskylä) being Sibelius-Academy in Helsinki. When also polytechnic schools started to train music therapists in 1990’s it became clear that the role of University should be more on further education and research activities than on basic education.

On the one hand the state authorities started to demand more proofs of the effects of this new therapy profession, on the other hand also some of the clinicians wanted to get more profound picture of, as well as to expand their scope (in many ways) within the profession. The lack of competent teachers in the field of music therapy education was obvious as well. The natural phase to make this reform was the year 1997 when a temporary but however the first full-time, post of associate professor was established. A few years later the post was changed for
the post of professor, and since the year 2002 this post was formalised.

Requirements, structure and content of the Masters programme

Our Masters programme is spread over two years period. Previous music therapy studies are required and most often our students are qualified clinicians graduated from any of the Finnish clinical trainings. In the light of the two-stage Bologna model, the question is about 120 points programme presupposing additional 180 points as previous studies. At the University of Jyväskylä the full adoption of the Bologna model will be made within the next two years.

The first year of the studies requires two days’ attendance weekly at the University during the both terms. It includes lectures, demonstrations, workshops and seminars mainly in areas like qualitative and quantitative methodology, theory, assessment techniques (clinical work), academic writing skills, and project administration. The second year is based on periodical meetings (2-3 times within a term) consisting mostly of seminar-like working on various topics. The aim is that a student could finish his/her Masters thesis by the end of the fourth term (we have two terms within a year).
Depending on the resources we have 2-4 visiting lecturers from abroad within a two years’ cycle. At least one of the seminars is arranged as mini-conference and students’ presentations on their research projects are made in English. Visiting lecturer work as supervisor in these situations and our PhD students participate in these mini-conferences too.

**PhD studies**

For those who are interested in postgraduate studies we have shared system together with musicology and music education. Each of the professors (4 in all at the department) has their own areas of concentration and they negotiate together how the supervision will be carried out in particular cases. In our system of degrees and curricula we have a stage called Licentiate’s degree between the Masters and PhD degrees. It is not necessary to do the Licentiate thesis but for many reasons most of the postgraduates want to do it.

At the moment we do not have a specific PhD school with scholarships for music therapy PhD -students. Thus, our PhD -students have to do their doctorates along with their clinical work. Some students have been successful to get grants for preparing their thesis. The grants are usually for relatively short time, from 6 months up to 12 months at a time.

**Completed theses**

Since 1989 when the first Masters thesis was completed the statistics goes as follows:

Masters thesis (22)

Licentiates thesis (3)

Doctoral thesis (1)

Masters theses fall into next categories:

Case studies (13): psychiatry (3), cancer patients (2), old age (2), dysphasia (2), addicts (1), autism (1), cross-cultural (1), mentally or physically handicapped (1)

Theory (4): psychiatry (2), music and emotions (1), music as expression (1)

Assessment (2): mentally retarded (1), psychiatry (1)

Healing potential of Karaoke singing (1)
Identity of music therapist (1)

The three licentiates theses are (they all are in Finnish):

Music and emotions in music therapy – a model on the emotional meanings of music (Jaakko Erkkilä, 1995)

On the bridge of musical experience – gender related meanings in the light of the music preferred by psychiatric patients (Merja Niemelä, 1998)

Counter-transference responses in visual and auditive communication of music therapy from the point of view of positivity and negativity (Kari Syvänen, 1999)

The doctoral thesis is:

Meaning levels of music from the point of view of the theory and clinical practice of music therapy (Jaakko Erkkilä, 1997) – available only in Finnish but there are two articles based on this dissertation: Erkkilä, 1998; Erkkilä 2001 (see the Finnish database included in the CD ROM V and VI)

Ongoing PhD studies

Ala-Ruona, Esa: “Initial Assessment of Psychiatric Client in Music Therapy”

Kaskinen, Mirja: “History of Finnish Music Therapy”

Kanerva, Eila-Sisko: “Music Therapy in Scandinavian Countries”

Niemelä, Merja: “Music Therapy with Veterans (War 1939-1944)”

Punkanen, Marko: “Physioacoustics and Music Listening in the Music Therapy of Drug Addicts”

Ravattinen, Jaana: “Cross-cultural Music Therapy in Finnish Context”

Riikkilä, Kari: Starting his PhD in the project: “Intelligent Music Systems in Music Therapy”

Salo, Juha: “Combination of Music Therapy and Music Education Methods in the School for Disabled Children”

Syvänen, Kari: “Musical Counter-transference Reactions”
Valve, Juha: “Music Therapy as part of rehabilitation of Special Children”

Varkila, Leila: ‘Overall Music Therapy Assessment of Developmentally Retarded Patients”

Presentations in international congresses


Visitor lecturers

Aldridge, David (Germany), Amir, Dorit (Israel), Bonde, Lars Ole (Denmark), Bruscia, Kenneth (USA), Leth, Per (Denmark), Nygaard-Pedersen, Inge (Denmark), Stige, Brynjulf (Norway), Thomasen, Ellen (Denmark)

Research projects

Gambling addict project: A project where multi-methodical approach, including music therapy methods, were applied. The data was gathered between 1996-1999. The final report was published in 2001.

Publications:


Intelligent music systems in music therapy: A three years’ research project funded by Finnish Academy. Starting on August 2003. Will be employed two researchers (1 post-doc, 1 PhD-
Persons in charge:

Petri Toivainen, professor, University of Jyväskylä, Department of Music, Cognitive musicology

Jaakko Erkkilä, professor, University of Jyväskylä, Department of Music, Music Therapy

The objectives of the project are: (1) to develop methods for automatic music analysis that can be used, among others, in analyzing improvisations produced in clinical music therapy; and (2) to develop interactive music systems that facilitate clinical music therapy work with persons having limited motor abilities. To develop automatic music analysis systems, various algorithms for musical feature extraction will be applied and further developed. Using psychological tests, the connection between these features and perceived qualities of improvisations will be examined. This will yield a system that maps musical input onto profiles that predict various perceived qualities of the input. Interactive music systems will be developed by applying methods of pattern recognition to various sensor data, such as a video stream. The motion data thus obtained will control chosen musical features, such as tempo (beat-tracking based on adaptive oscillators). The development of these systems will be carried out in collaboration with clinical music therapists, and their suitability will be assessed by interviewing both therapists and clients.
Welcome to our summer edition of "Music Therapy Today".

This issue deals with a wide ranging topic, that at times is controversial, which is the use of music and substances to bring about changes in consciousness. There is a tradition of using music and consciousness-changing substances in a variety of cultures (see articles from Maas & Strubelt, de Rios and Fachner). Such substances may also be abused by being taken out of context and lead to addiction and suffering. In the treatment of addictions using music therapy, we have articles by about "dangerous music" (see Horesh) and gambling (see Erkkilä). This issue contains a Book Review from Laurin Haakvoort of "Music Therapy".

Modern music therapy in it's very beginnings has been traced as a shamanistic tradition, the actual appearance of a music therapist dressed like a shaman from Africa or the Tibetan highlands would surely be a stimulating event on a ward in a western hospital. The traditional healing context provides signs of authorisation and symbols. In the western world, we also have healing symbols within ritual contexts; the white and coloured uniforms of hierarchical authority, the green gowns for specially reserved areas of blood rituals - operating theatres, the symbolic snake of healing - stethoscope around the neck, and our privatised spaces of ritual - the consulting room (see Aldridge 2000).

And then there are the rites of transition within our culture. Not simply adolescent to adult, but younger adult to middle-aged, and then middle-aged to senior citizen. And in the clinic, we have the transitional phases from sick to
well, from disease to rehabilitated. Yet we rarely interpret events in this manner. Language is also part of ritual. How and what we describe is dependent upon the healing culture.

Parents might be alarmed if a therapist in the hospital proposes to them that their adolescent is struggling with his steps to become a man and needs a ritual using music and dance sessions intensified and deepened by certain psychoactive drugs to integrate his development in becoming an adult. Uwe Maas and Süster Strubelt describe in their article "Music in the Iboga initiation ceremony in Gabon: Polyrhythms supporting a pharmacotherapy" such a ritual held in a traditional setting. When the ritual is over, there is a party using same substances as in the ritual as well, but the ritual comes first and the use of the psychoactive drugs has a specific function, time and place (Metzner, 1992). Maas describes his personal experiences and then he takes a scientist's stance describing the music and the substance used to evoke imagery of traditional known content. As music was used in guided imagery, when Helen Bonny prepared the music for the LSD-Sessions (Bonny & Pahnke, 1972), Maas demonstrates that the careful, traditional and embedded use of substances can support the function of music in a psychotherapy session. If you would like to listen to how this music sounds, then see our Music Showcase. What is striking in this article is that a European has access to a repertoire of imagery in an African context, which should lend a further salience to Guided Imagery in Music practitioners.

To extend further a connection with GIM, Marlene Dobkin de Rios in her article "The Role of Music in Healing with Hallucinogens: Tribal and Western Studies", says ,If these hallucinogenic substances are to be used psychotherapeutically in the future, the role of music as a primary conditioning agent of the experience will have to be taken into account. Any planning for psychotherapeutic intervention in times to come would necessitate a clear musicological approach to create therapeutic states of consciousness." De Rios has been researching the use of music and drugs for about 35 years now and provides us with an overview and short reflection on her research work concerning shamanistic studies in the Peruvian rain forest.

These two articles might show what is possible when there is a culture of using
consciousness-changing pharmaceutical agents and music in a guided setting. An ethno-musicological perspective demonstrates links between music therapy and music in other ritualised settings. Powerful evoked visions and experiences serve psychotherapeutic aims when guided. However, the unguided use of hallucinogenic drugs and music can lead to serious problems.

Tsvia Horesh, in her article "Dangerous Music - Working with the Destructive and Healing Powers of Popular Music in the Treatment of Substance Abusers", tells of her work with clients that cannot listen to certain music anymore without thinking of using drugs. Unguided drug experiences may lead to an emotional craving for party feelings intensified, or evoked, with drugs. She discusses a culture of addiction, which ties people more and more into a state of addiction.

The article "Jazz, improvisation and a social pharmacology of music", from Jörg Fachner, also discusses aspects of use of consciousness changing agents and music and shows a possible benefit that musicians or music listeners might experience when using cannabis as an intensifier of music perception. From his stance of social pharmacology, the context of using such agents, particularly cannabis, is dependent on shared personal preferences. He reminds us that how we view such substance use is a political act and this extends to the current bans on raves as a potential site for misuse where Clean-up Act passed by the United States Congress in April 2003 threatens to close down rock concerts, rave parties or Hip Hop jams. Such events are suggested as sites in a culture of addiction (infos under www.drugpolicy.org; www.nomoredrugwar.org). Not only a substances being banned but also sites for performance being restricted which is a remarkable throwback to the years of prohibition and a massive assault on civil liberties.

The last article in this series comes from Jaakko Erkkilä. He presents a research project on "Music Therapy Methods In The Treatment Of Gambling Addiction". Music therapy helped the clients to relax and to reduce stress, provided a compensating pleasurable experience, helped to extend expression in non-verbal and emotional areas, and stimulated speech.

The use of music therapy in forensic psychiatry is a challenging area of
practice and we hope that this article stimulates further contributions from music therapists, musicians, anthropologists, music-ethnologists and clinical practitioners of varying persuasions.

Shamanism is currently becoming a fashionable activity but the traditional calling to become a shaman involved an arduous and complex journey (even more arduous than a music therapy training). The rites of shamanism focus on the ability of chosen individuals to enter a trance and embark on soul-journeys to achieve certain specified ends - healing the sick, predicting the future or generally liaising with the attendant spirits of their group. It is distinct from magic and from a conventional priesthood in that the shaman is not merely interceding on behalf of the person, but has an active relationship with the spirits. He, or she, flies with the spirits, argues with them, exorcises them, negotiates with them, and may even have sex with them. But the shaman has migrated from the mysterious world of Siberian cosmology to a Western retreat. It is not hard to see why. The shamanic performance often involves a bout of giddying sensual derangement followed by an extended hallucinatory mission amongst the spirits. Although psychotropic substances played only a small part in Siberian shamanism, many of the accounts of spiritual journeys appeal to the urban shamanism of "off-road religion" in a Westernised form (see Aldridge, 2000) with the added potential of psychoactive substances. Such modern rituals offer personal transcendence and psychological improvement, completely estranged from the communal consequences of traditional practices. The shaman, however, is a compelling archetype of the hero who starts out crazy and ends up a revered and creative seer, spreading a poetic and palliative wisdom among his peers. What better romanticized model of the music therapist can we find? Yet, the initiation of shamans involves a dissembling of the self so intense that it looked like a psychotic episode and the emphasis of the ritual is as a sacred event for the community. We can learn from other cultures, but we have to be careful about what we adopt out of context, both for the protection of our patients but also the protection of our selves. While the model of the shaman may be compelling, there are irreconcilable differences in practice and concept (see table below) that the model falls down. Furthermore, why would we want to convert ourselves into healers of a bygone age and different culture, when the challenge is to meet the needs of our patients or clients in the 21st century?
### TABLE 1. Differences between health practitioners, modern spiritual healers and traditional shamans

<table>
<thead>
<tr>
<th>Music therapy practitioner</th>
<th>Traditional shaman</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-selection to a professional group by career choice.</strong></td>
<td>Selection by crisis or inheritance</td>
</tr>
<tr>
<td><strong>No initiatory crisis, pathological crisis may be a hindrance to vocational training.</strong></td>
<td>Initiatory crisis sign of vocation, pathological crisis necessary for vocation</td>
</tr>
<tr>
<td><strong>Personal quest acceptable</strong></td>
<td>Personal quest devalued or irrelevant</td>
</tr>
<tr>
<td><strong>Institutional training necessary to practice.</strong></td>
<td>No institutional training</td>
</tr>
<tr>
<td><strong>No arduous mental and physical ordeal</strong></td>
<td>Arduous mental and physical ordeal</td>
</tr>
<tr>
<td><strong>Limited apprenticeship</strong></td>
<td>Long apprenticeship</td>
</tr>
<tr>
<td><strong>Legitimacy bestowed by institution on behalf of the community (licensing)</strong></td>
<td>Legitimacy bestowed by community</td>
</tr>
<tr>
<td><strong>No kinship ties</strong></td>
<td>Kinship ties</td>
</tr>
<tr>
<td><strong>Variable status</strong></td>
<td>High status</td>
</tr>
<tr>
<td>Patient removed from environment, often treated behind closed doors, with the focus on individuals or dyads, sometimes as family or social groups.</td>
<td>Patient treated within the community as public phenomenon.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Patient is the agent of their own healing and responsible.</td>
<td>The shaman is the agent of cure and responsible for the results.</td>
</tr>
<tr>
<td>The patient takes the psychoactive substances.</td>
<td>The shaman takes the psychoactive substances.</td>
</tr>
<tr>
<td>There are time restraints to consultation.</td>
<td>No time restraints to consultation.</td>
</tr>
<tr>
<td>For the individual good of the patient.</td>
<td>For the social good of the community.</td>
</tr>
<tr>
<td>For the material or personal gain of the therapist.</td>
<td>A sacred event for the community with no personal benefit for the shaman.</td>
</tr>
</tbody>
</table>

**References**


Music in the Iboga
initiation ceremony in
Gabon: Polyrhythms
supporting a
pharmacotherapy

Uwe Maas and Süster Strubelt

Abstract

Music is used by traditional cultures worldwide to create and accompany trance states. However, the influence of sophisticated compositions and the choice of instruments on patients’ recovery has been hardly examined. Rouget (1990), in his comprehensive overview, assumes that the choice of instruments and music is insignificant. We had the opportunity to assist several Iboga initiation ceremonies in 1999, 2001 and 2003 in Gabon (Central Africa). We recorded the music and finally decided to become initiated ourselves. The Iboga healing ceremony induces a near-death experience and is performed to cure serious mental or psychosomatic diseases, but people also undergo initiation rites for reasons of spiritual or personal development.

After an analysis of the compositions and their function in the ceremonies we come to the conclusion that neither the musical structures nor the choice of instruments should be seen as cultural and incidental qualities: There are indications of direct somatic influences apart from the psychological ones. Not only the absolutely consistant basic metre and the incessant use of polyrhythms, but also the harmonic organization and the choice of instruments in all probability serve to activate the cerebellum and generate theta-frequencies in the EEG. These methods seem to be used consciously to induce particular reactions, e.g. possessional trances and visions. We suppose that the music increases the effect of the drug
Ibogaine which is used during the initiation ritual so that patients may need smaller amounts only of this potentially harmful drug.

**Introduction**

In many traditional cultures, young adults experience an encounter with death during their initiation ceremony. For this purpose the pygmies use the root of the Iboga shrub. Initiation with this drug was imitated by several other ethnic groups who thought this drug to be more effective than their traditional initiation drugs. In the middle of the 20th century Iboga was discovered in Gabon as a remedy for serious mental or psychosomatic disorders. Consequently the average age of persons being initiated has risen; instead of the traditional initiation rituals on reaching puberty, initiations in the urban sector often serve to solve serious problems or fulfill a desire for self-awareness. Admission to the community of adults of the pygmy village is replaced by admission to the community of initiated people who also meet in future, organize ceremonies and who offer social protection (Goutarel 2000, Gollhofer and Sillans 1997, Mary 1983).

During a stay in Gabon in 1999 we met traditional healers of the ethnic group of Mitsogo in the region of Lambarené and studied their work.

FIGURE 1. Typical Mitsogho village

Having observed several initiation and curing ceremonies, and having recorded and analysed the music played during the ceremony, we decided to get initiated ourselves by the Mitsogho in Mitoné in December 2001 (U.M.) and in April 2003 (S.S.). We will concentrate on the Missoko initiation for men. Women’s Mabandji initiation, which includes possession trance, is the topic of a separate paper. We start with the report of Uwe Maas’ experience with the Missoko initiation. We will report pharmaco-
logical results about the drug Ibogaine used in the ceremony, and then analyze the musical compositions and the ritual use of instruments. At the end, we will propose some hypotheses about the neurophysiological effects of the music and interferences between music and drugs.

1. Personal experience: An initiation report by Uwe Maas

Six experienced male healers and musicians who accompanied the ceremony for the two nights, two female healers and the community of the village took part in my initiation among the Mitsogho people in the village of Mitone near Lambarené in December 2001.

I was fitted out with ritual weapons and protective objects for the encounters in the spiritual world. Just before sunset, having consumed about 150-200 g of the Iboga root’s bark piece by piece, I reacted with nausea, coordination problems and tremor on the left side. I had a typical out-of-body experience in which I experienced myself as a football-sized spiritual being moving through visionary spaces.
Simultaneously I perceived external reality so that I was able to communicate about and inform the others about my experiences. I moved around floating over tropical steppe and river landscapes, through long white corridors, with a countless number of doors, as well as under water without any (physical) resistance. I met several groups of people who seemed to have lived in older times and I met myself (as an independent individual).

My initiated attendants asked me to become active in this world: to move around, to open doors and to get in contact with the people I met. At first I had some problems with the (mental) movement and it was difficult to communicate. It took me about half an hour to learn this. Strangely enough, the mental communication then worked also in the “worldly”
reality: I was able to make out every detail of my companions’ faces although it was almost completely dark and I was sure that I could read their thoughts – especially these of the musicians.

At the end of the visions, while the dimensions of space and time changed in a peculiar way, I had a vision (similar to a parable) which impressed me as divine.

The initiated persons around me – approximately 15, many of whom had travelled to Mitoné just for the initiation of a German - didn’t have any problems to control me on my journey and to classify my experiences. My friend, and father-of-initiation, Antoine Makondo in particular, who had been looking forward with excitement to my reactions, was apparently pleased that I saw the pictures he expected. The Mitsogho obviously had their (secret) criteria which enabled them to classify the visions of a foreigner. For example, I was sometimes prevented from speaking in order not to pass on secrets which were only meant for me. The interpretation seems to be independent of the initiate’s personal knowledge because the aim of the initiation is not to investigate the initiate’s past but a general experience: The journey into the hereafter, the encounters with dead people and with God, the experience of dying and rebirth. The Mitsogho realized that their European friend could make this experience, too.

After about six hours the intensity of the visions wore off and I became very tired. I leant against my mother-of-initiation who sat behind me and I began to return back to life. This period was accompanied by singing and elements of physical therapy. To loosen up my “rigor mortis”, all my joints were moved – which, to my surprise, cracked audibly! – and I was asked to get up and make some easy movements, with the prompt result of dizziness, vomiting and new visions. After a rest I was supposed to
dance for the first time in the morning and to take a ritual bath in the river. Afterwards I became partly isolated to mark the beginning of a new phase of my life. I was only allowed to talk to initiated persons, and in a ritual way. The ceremony came to an end with a dance celebration where I was admitted into the community of the initiated and simultaneously released into my real life (Figures 3+4).

**FIGURE 3. On the way to the ritual bath**
2. The Iboga ceremony as a controlled near-death experience

Our visions during the Iboga initiation correspond with the experiences of other Europeans (Samorini 2000), with ethnological descriptions (Fernandez 1982) of out-of-body-experiences among the Gabonian Bwiti, and with reports by people who were very close to death. Greyson (1984) isolated four aspects of a near-death experience: a cognitive factor (acceleration of time, review of one’s life, global understanding), an affective factor (feelings of joy, harmony and peace, a vision of an eternal light), a factor of paranormal experiences (transcendental perceptions, a view of the future, out-of-body-experiences) and a factor of transcendental experience (entering another world, encounter with mystical beings,
deceased persons or gods). The psychological consequences of near-death experiences have been examined by various authors (Groth-Marnat and Summers 1998, Insinger 1991, Flynn 1984). Flynn (1984) interviewed 21 persons who remembered a near-death experience. Nearly all of them were less afraid of death and more likely to believe in life after death. Most of them also believed in a deeper meaning of life and had the impression of feeling the presence of God. Interest in material things had dropped whereas tolerance, empathy, sensitivity, understanding and acceptance of others people had increased. In addition, most of those interviewed were less dependent on the opinions of others.

Groth-Marnat and Summers (1998, S.118) explored changes of personality after near-death experiences. They summarize their results by saying “There is a general agreement that changes include greater concern for others (patience, tolerance, understanding), a reduction of death anxiety with a strengthened belief in an afterlife, greater transcendental feelings, a reduction in materialism, increased self-worth, greater appreciation for nature, and increased awareness of paranormal phenomenon.”
These after-effects of spontaneous near-death experiences correspond with the expectations that Gabonian healers have of the initiation. According to the traditional healer Antoine Makondo, the initiation should not be considered as a direct form of healing but as a method to broaden one’s self-concept. It would allow you to see the world with different eyes and to see and resolve problems in a new and better way. It should be a step towards a new spiritual vision of the world. In conversations with initiated males about the results of the experience we were told that they had become more adult, had given up bad habits like chatting up women, lazing around etc. They had started a serious life, got married, searched a job etc.. Women opt for initiation if they have difficulties becoming pregnant.
In addition to the general near-death experience, the initiation allows a controlled, and longer, journey into the hereafter, facilitates the processing of infancy experiences and also brings contact with dead relatives.

3. **Pharmacological effects of Ibogaine**

**FIGURE 6. Iboga shrub**
There are a lot of studies about Ibogaine, the extract from the Iboga root, because American scientists have explored its possible use in drug therapy (heroin, cocaine, alcohol). Preclinical studies show that a single dose of Ibogaine may have spectacular results: Without any withdrawal some addicts “forget” their addiction. Others have profound experiences after consumption of Ibogaine (e.g.: see themselves in a grave during the vision) so that they decide to give up drugs. The effect usually lasts for a few weeks or even months but unfortunately a lot of people take drugs again after this time. Pharmacological studies with mammals came to the same result: Animals which were given drugs regularly were less interested in them after consumption of Ibogaine. The fact that Ibogaine has been classified as illegal in the US (and in most European countries) is the reason why clinical examinations have not been possible so far. Ibogaine is an illegal drug in most countries, and there are doubts about clinical studies, as it is known that several people died after the consumption of Ibogaine for reasons unknown.

A large number of animal experiments (in vivo and in vitro) with effects of Ibogaine on the different neurotransmitter-systems (dopamine, serotonin) produced a lot of interesting, but partly contradictory, results which were probably caused by complex interactions between the different neurotransmitter-systems that have not been examined yet (Alper 2001, Goutarel 2000). The fact that Ibogaine creates near-death experiences has been almost completely ignored in pharmacological literature. But there are similarities between near-death experiences and impacts of Ibogaine on the pharmacological level. Ibogaine affects the cerebellum in the same way as ischemia. An overdose of Ibogaine kills certain groups of Purkinje cells, the same groups that die under ischemia (Welsh et. al. 2002). Purkinje cells are much more susceptible to cell death than other neurons. They might have the function of a fuse. With Purkinje cells
being destroyed, the brain would adopt measures to protect the rest of the cells. Some authors believe that the near-death experiences belong to these measures (Whinnery 1997). Like ketamine, which also produces near-death experiences, Ibogaine has neuroprotective effects; this means it protects neurons (but not Purkinje cells) from cell death (Alper 2001).

It is not very probable, that the amounts of Ibogaine which humans consume actually kill Purkinje cells, because none of the well-known consequences of serious ischemia have ever been observed after consumption of Ibogaine. But we suspect a negative effect on the cerebellum for a short time, compensated later on by increased activation. Even increased cell growth might be assumed after the life-threatening situation, as demonstrated for cells in the hippocampus after global ischemia (Takasawa 2002).

The functions of the cerebellum remained a mystery to scientists for a long time. It has more cells than the rest of the brain. For a long time they were supposed to do nothing but support motor learning. The participation of the cerebellum in cognitive and creative tasks of the brain was investigated only recently (Leiner et. al. 1993). Ivry (1997) supposes that the cerebellum contains one (or several) “internal clocks” of the brain. Studies proved that people with damages of the cerebellum showed poor results in estimating short-time intervals compared to people with damaged neocortex.

Recent studies also found correlations between mental illness and growth of the cerebellum. Persons suffering from schizophrenia, trauma or addiction were shown to have a smaller cerebellum than controls (Anderson et. al. 2002, Jurjus et. al. 1994).
4. Music therapeutic aspects of the ritual

To the Mitsogho, continuous musical support from musicians playing the mouth bow and the harp, accompanying percussions and singing is essential for the initiation process. Music is the “life-line” that reaches from this life to the hereafter and serves as a means of locomotion in visionary space. And that is exactly our own experience, the renewed onset of musical accompaniment, after short interruptions, reactivates the faltering visions, facilitates spiritual communication and improves mental and physical well-being considerably.

Apart from our own Missoko and Mabandji initiation respectively, we were able to observe two Mabandji initiation ceremonies and three healing rituals including possessional trance states among the Mitsogho tribe, and three Mabundi initiation rituals among the Fang tribe. We recorded about forty hours of ritual music all together, to be analysed in detail as follows.
4. Music therapeutic aspects of the ritual


4.1 MUSICAL STRUCTURES; BIMETRICAL STRUCTURE WITH CONTINUOUSLY CHANGING ACCENTS

FIGURE 7. Visualization of a 4:3-polyrhythm on the back of a harp. From author’s collection

The music has the specific structure of a twelve-beat metre with an ambivalent division in 6 x 2 and 4 x 3 impulses:
Between these (not always percussively marked) metrics, we have the periodically repeated melodic motive; its melorhythms cannot be clearly associated with one of the two, and through continuous minimal variations it emphasizes one and then the other. In the trance-inducing phase, there is a striking increase in the number of rhythmic changes resulting from overlapping of different, very fast rhythmic elements. Rattles and ankle bells which systematically ring out between or beside the fundamental beat make the ritual music even more complex.

In the following example a dominant solistic clapping in a 3x4-metre is introduced, overlapping the 4x3-metre of the rattles and thus giving a new rhythmic interpretation to the melodic motif (sound 1: mp3 - 852 kb).

**Table 1. Polymetric placing of accents on 12 elementary beats at the time of X**

<table>
<thead>
<tr>
<th></th>
<th>6x2-metre = „waltz time“</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
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<tbody>
<tr>
<td>4x3-metre = „marching time“</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

**Table 2. Polyrhythmic harp music with polymetric clapping**

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<thead>
<tr>
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<th>x</th>
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<td>A</td>
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<td>x</td>
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<td>CC</td>
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<td>C</td>
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<td>RA</td>
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<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
</tbody>
</table>

Line 1-7 = relative pitch of the harp strings at the time of X
CC = joint clapping at the time of X
SC (blue) = dominant solistic clapping at the time of X
RA (yellow) = forward movement of rattles at the time of X
From left to right: elementary beats (smallest metrical units)
4. Music therapeutic aspects of the ritual

Ritual meaning:

"There are always various paths and multiple crossroads." (Magui Abaniz Lubin, traditional healer at Medang-Nkoghe near Lambaréné)

- **Perfect alternating balance for basis chords, melodic moves and rhythmic patterns**

The following piece for harp illustrates these principles; based on 16 elementary beats (which is unusual), with alternating binary and ternary melorhythm, its typical 3:2 interlocking of treble and baseline, inversion of the two minor chords after 16 elementary beats and continuous mirroring of the melodic movements between root and third on one hand and fifth and octave on the other ([sound 2; mp3 - 2.9 MB](http://musictherapyworld.net)).

**TABLE 3. Polyrhythmic harp music with horizontal and vertical mirroring**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>E'</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D'</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>H</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>A</td>
<td>X</td>
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<td>G</td>
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<tr>
<td>E</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>D</td>
<td>X</td>
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</tr>
</tbody>
</table>

Line 1-8 = relative pitch of harp string at the time of X
From left to right: elementary beats (smallest metrical units)

We assume this continuous alternation reflects and supports the tightrope act of the person to be initiated ("ecstatic" instead of "static").

- **Periodical repetitions with continuous minimal changes**
The melodic motifs are repeated mostly after 2x12 or 4x12 elementary beats and undergo minimal melodic or rhythmic variations. Here the melodic rhythm frequently diverges slightly from the elementary beats, thus suspended between the two fundamental metrics (Sound 3; mp3 - 3.7 MB). The repetitions lead to mental anticipations that are systematically frustrated by these minimal changes in order to "keep you on the move", as the Mitsogho told us: they create the open-minded attention that is required.

Ritual meaning:

"Flow" means transition between life on earth and the hereafter as well as "amniotic sac": "everything is moving in waves and cir-
4. Music therapeutic aspects of the ritual

4.2 Musical Instruments

4.2.1 Musical Instruments In The Missoko Initiation Ritual For Men

The mouth-bow "Mongongo".

FIGURE 9. Playing the mouth-bow

- Principle of sound production:
The musical instrument is similar to the pigmy hunting bow. The "arrow" strikes the bowstring and causes it to vibrate. The root may be elevated about one tone with a wooden or metallic object pressed against the string. The musician varies the volume of the oral cavity and is able to produce about eight different overtones corresponding to the root (like on a Jew’s harp).

- **Tonality:**

  Two major chords, the roots of which differ by one tone approximately.

- **Principle of composition:**

  The root’s moves are often mirrored after 12 elementary beats, the predominantly contrapuntal treble (overtones) is either mirrored or shifted vertically ([sound 4; mp3 - 1.5 MB](https://musictherapyworld.net)).
As to melorhythms, the first six elementary beats are often divided into three, the second into two parts (sound 5; mp3 - 1,2 MB).

Ritual meaning:

“Male” main instrument in the Missoko initiation ceremony. The overtones (corresponding to their “immaterial” origin) are considered to be the voice of the creator.

Bamboo canes knocked into the ground.
4. Music therapeutic aspects of the ritual

Differently pitched large bamboo canes accentuate different metres (6x2, 4x3, 3x4, 2x6) (*sound 6; mp3 - 2,3 MB*).

**Ritual meaning:**

“The sweeter and more complex the music, the longer the journey.” (Marius Osseye, traditional healer and professional harp player)

**Instruments with a latency period between movement and sound.**

Several instruments are used in the Missoko initiation ritual the construction of which makes exact timing very difficult (*sound 7; mp3 - 2 MB*):

1. A special bell fixed onto a curved handle (thus moved from „diagonal behind“) produces a clattering sound
2. rattles made of seed capsules attached to cords (played right-handed, 

3. “straight” 4x3-metre)  
4. the “fly brush” Mognangui (picture 3) (played left-handed, “uneven”  
   6x2-metre).  

Their delayed, vague accents blur the fundamental beats.  

Ritual meaning:  

These “sacred” instruments may be played by initiated persons only (and the one to be initiated). The “fly brush” is an almost inaudible, therefore truly spiritual instrument.  

The traditional healer Antoine Makondo describes their function as follows: “It’s an education: There are always different paths you can follow”. We understand it as an indication of two alternative ways to cope with problems: adjust oneself to given facts (specific latency period between movement and sound – thus learning to move earlier) or calmly await what happens (appreciation of unexpected sound).  

4.2.2 Musical instruments in the Mabandji initiation ritual for women  

The eight-string harp “Ngombi”.  

4. Music therapeutic aspects of the ritual
4. Music therapeutic aspects of the ritual


- **Tonality:**

  Two minor chords the roots of which differ by one tone approximately

- **Principle of composition:**

  Polyrhythmic interlocking, mainly with different metres (6x2 resp. 4x3) left-handed (root and minor third) and right-handed (fifth and octave) ([sound 3: mp3 - 3.7 MB](sound 3: mp3 - 3.7 MB)).

---

**FIGURE 11. Antoine Makondo playing the harp**
Ritual meaning:

1. “female” main instrument in the Mabandji initiation ritual. Its sound symbolizes the lament of the mythical female ancestor Benzogho who sacrificed herself to bring Iboga to mankind.

2. “canoe” to cross the river between this life and the hereafter

3. representing the eight-legged spider that moves along a thread between heaven and earth

4. “family-therapeutical” instrument: the eight strings represents different members of the family. It is interesting that structures within the family have their counterpart in musical harmonies: The two alternating minor chords reflect the relationship between two nuclear families, the polyrhythmic play of the two hands stands for gender relations (the „spiritual“ 6x2-metre is usually attributed to the female part):

<table>
<thead>
<tr>
<th>Relative Pitch</th>
<th>Ritual meaning</th>
<th>Gender (treble/bass)</th>
<th>Classifying according to nuclear families (minor chords)</th>
<th>Generations (inversion of chords)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E’</td>
<td>mother</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>D’</td>
<td>aunt</td>
<td>X</td>
<td>X</td>
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<tr>
<td>H</td>
<td>sister</td>
<td>X</td>
<td>X</td>
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<tr>
<td>A</td>
<td>niece</td>
<td>X</td>
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</tr>
<tr>
<td>G</td>
<td>father</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>F</td>
<td>uncle</td>
<td>X</td>
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<tr>
<td>E</td>
<td>brother</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>D</td>
<td>nephew</td>
<td>X</td>
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<td>X</td>
</tr>
</tbody>
</table>

**TABLE 5. The meaning of the eight harp strings**
The wooden idiophone “Bake”.

**FIGURE 12. Playing the Bake**

The “Bake” is a board, about two metres long and seven centimetres wide, it is played simultaneously by two or three percussionists. While they independently stress different aspects of the polyrhythm, the resulting pattern is fast and permanently changing (sound 8; mp3 - 2,3 MB).

Ritual meaning:
When the primeval egg broke into two pieces, it created the principle of polarization in this world (night and day, birth and death, woman and man…) as well as the division of the spiritual world into three parts (as the Trinity in Christianity). This “transition” at the Big Bang is identified with a “cosmical forging” of this very loud and sharp-sounding instrument.

**The wooden rattle “Tseghe”**. Instrument shaped like a female figure, played before and during states of possessional trance ([Sound 1; mp3 - 852 kb](#)) played by spinning wrist movements (“diadochokinesis”).

**The ordinary rattle “Soke”**. These rattles accompany the mouth-bow; filled with seeds, they usually support the 4x3-metre, in the context of harp music and dance often the 6x2-metre ([sounds 4; mp3 - 1,5 MB](#) and [Sound 9; mp3 - 1,1 MB](#)).

**The drum “Balafon”**. Three or four differently tuned drums are played exclusively during the ecstatic dances that usually start about three o’clock in the morning. The rhythmic patterns are similar to those of the “Bake” ([sound 9; mp3 - 1,1 MB](#)).

**Vocal music**. There are no human voices in the spiritual world, that is why the person to be initiated is guided there by instrumental music. On the long way back to this life, however, he is welcomed by songs located between spiritual and earthly communication. The lyrics are only understandable to initiated people and use a lot of symbols - often they reinterpret opposite poles as circular processes - and frequently use a foreign language (Mabongo, for example, the language of the Pygmies from between Sindara and Mimongo). Thus, the content is transmitted partly “spiritually” and serves to hold the balance between this world and the spiritual one. ([sounds 2,7,9](#))

**Dancing**. There are three different styles of dancing:
1. Steps in a line in circles or wave-like movements like the mythical python (water spirit), rattles are shaken, often in a metre that complements the rhythm of the steps. Its name “Mayaya” has several meanings: “rebirth”, “peace”, “release from dependent relationship”, “relief from segregation” in the Mitsogho language.

2. An individual dance for men only whose slow movements seem to express the tension between self-control and liberation.

3. The ecstatic dance with rapid, wiggling hip movements. Its performance serves as proof of a successful initiation process. It symbolizes the vortex of birth and death as transition processes.

5. Hypotheses on neurophysiological effects of ritual Mitsogho music

During our initiation ceremonies, we felt a direct influence of music on our feelings and the pictures we saw during the visions. This was especially strong when we were moving ourselves to the music. Is music a kind of medicine that provokes specific physiological reactions, which promote trance states? And if this is so, how do the reactions to music interfere with Ibogaine-induced effects?
5. Hypotheses on neurophysiological effects of ritual Mitsogho music

5.1. INDUCTION OF TRANCE AND THETA-WAVES

FIGURE 13. Wavy mangrove roots, Cap Esterias near Libreville

Neher (1962) reports laboratory research results that demonstrate that flashing lights as well as rhythmic drumming of theta-frequency (4-7/sec) generate EEG-waves of the same frequency and hallucinations. Goodman (2000) studied the impact of rhythmic stimulation on persons assuming ritual body postures known from native Indian civilizations. The traditional rhythms of 6 hertz originated theta-waves in the EEG. Some of the participants reported out-of-body experiences.

Body and Stevens (2000) augmented theta-activity in the neocortex by binaural beat stimulation. This stimulation, slightly different for both ears, was also used in the initiation ceremony of Uwe Maas at the culmination of his visions.
The musical theta rhythm is maintained for days in the Bwiti ceremonies. It corresponds to a spontaneous trembling (or voluntary movement) of the left hand of men and the right hand of women. This tremor is probably caused by Ibogaine effects either on the cerebellum or on the dopamine metabolism.

We think the EEG theta-rhythm is also supported by the polyrhythmic structures of the music. To play the rattle with the frequency of the elementary impulses (including the forward and backward movements) could be a „mathematical“ solution to endure the different rhythms. Our own experiences show that the perception of inner wave-movements (with a frequency of 6 hertz) continues even when the music stops. Time is no longer felt as a line but as a circle. The inner metrum is felt for days and continues even at night, underlined by the music, which is often also played while the person to be initiated is sleeping.

Music activates the cerebellum like Ibogaine; complex and unknown music is especially stimulating (Satoh 2001, Khorram-Sefat 1997). Dancing and playing the rattles is even more activating than music alone. Quick hand-movements, necessary to play the wooden rattle Tseghe, are known to medical students as diadochokinesis. Patients with cerebellar lesions have problems with this kind of movements. We suppose that the typical Bwiti dance with quick hip movements, performed by the initiated at the end of the ceremony, also requires an activated cerebellum. The dance is seen by Gabonian healers as indication of successful initiation.
FIGURE 14. The final dance

We think that activation of the cerebellum by music and movements enhance the effects of Ibogaine. We assume that the cerebellum is also responsible for changed time perception experienced under Ibogaine influence, and by near-death experiencers. Montain climbers and racing drivers who survived accidents often report that they were able to think extremely fast in seconds of extreme danger. Brain structures obviously accelerate thinking processes in moments of risk (Noyes and Kletti 1982). These phenomena occur independent of brain ischemia. Cerebellar structures, the inner clocks, may play an essential role in the acceleration of brain processes. The cerebellum was perhaps much more important for mankind in epochs when men were hunters and threatened by wild animals and quick reactions were essential for survival.
5.3 POLYRHYTHMS TO INDUCE OR DEEPEN STATES OF TRANCE

There are few studies about the effects of polyrhythms on the human brain.

Neher (1962) reports that optic stimulation by two independent flashing lights induced hallucinations under laboratory conditions. But the effects of acustic polyrhythmic stimulation have hardly been investigated. So we can only hypothesize on this subject. During Iboga ceremonies, music is not only an object of reception: people walk around, dance, play the rattle. Gabonian women are able to walk in a 4x3-rhythm and play the rattle in a 6x2-rhythm at the same time. How do they manage to do so and what might be the purpose of such a performance?

Ivry (1997) presumes after several perception studies that the cerebellum has not only one but various „inner clocks“. Tapping a rhythm with one hand is directed by the lateral cerebellum. Subjects with cerebellar lateral lesions perform poorly in this task. But they show much better results with both hands. The fact that contralateral cerebellum does not influence tapping of the other hand was seen by Ivry as an indication that the cerebellum has at least two, and probably more, inner clocks. Consequently, the cerebellum is able to perform several rhythms at the same time, while our consciousness cannot think two parallel rhythms. Studies with musicians found performance of polyrhythms based on only one principal „inner clock“. One rhythm was always more accurate than the second one (Pressing 1996). Thinking two rhythms at the same time, as Mitsogho music suggests and as Gabonian women seem to practice when dancing and playing different rhythms at the same time, requires changes in brain functions. These might include a separation of consciousness from cerebellar activity, or a unilateral activation of the right brain hemisphere, which can tolerate contradictions better than the left hemisphere. Activation of the right hemisphere is presumed to play a role during near-
death experiences as well, which are frequently experienced in epileptic attacks of the right temporal lobe (Schröter-Kunhardt 1999).

The result of polyrhythmic stimulations could thus be cerebellar activation (useful to find quick and creative solutions) and/or stimulation of the right hemisphere (useful to detect hidden unconscious contents and also for creative thinking)

FIGURE 15. Bapunu mask, from author’s collection
Concluding remarks

Unfortunately, there are only a few areas where we have a chance to compare African traditional knowledge and international research results. Neither pharmacological, nor musical brain research, has provided sufficient scientific results to compare both areas. But in all cases where it was possible to compare western science and traditional knowledge we found that medical knowledge of traditional healers was „state of the art“. Their statements about Ibogaine effects, the danger for women, the possibility of interactions and complications between Ibogaine and other drugs have been substantiated by Western medicine. And we ourselves found that Gabonian statements about the effects of the music were true for us. We believe that many procedures in Bwiti are based on neuropsychological knowledge, although it is not yet proven by international science, because international science has hardly made efforts to investigate these subjects. We think it could be useful for pharmacological and musical science to formulate hypotheses on the basis of the knowledge contained in traditional medicine.

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**Authors:**

Süster Strubelt (psychologist and sociologist)

Uwe Maas (pediatrician and musician)

Röhrchenstr. 63, 58452 Witten, Germany

e-mail: umaas@scientific-african.de

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The Role of Music in Healing with Hallucinogens: Tribal and Western Studies

Marlene Dobkin de Rios, Ph.D.

Introduction

Over the last 35 years, the author has studied the role of plant hallucinogens in tribal and third world societies (see Dobkin de Rios 1972, 1984, 1994). Several articles have examined the role of music produced by shamanic healers as adjuncts to their healing rituals, particularly with such plant hallucinogens as ayahuasca (various Banisteriopsis sps.), as well as other hallucinogens (De Rios and Katz 1975, Katz and De Rios 1971). In Hallucinogens: Cross-cultural Perspectives (1984:211), a table was compiled of the then described music that accompanied psychedelic rituals world-wide. They included, among others, tropical rain forest native Indians such as the Chama and Cashinahua of Peru, the Huichol of Mexico, the Jivaro of Ecuador, and the Kiowa and Comanche Indians of North America. It appeared that percussion and drumming were the major modalities used.

1. Associate Clinical Professor of Psychiatry & Human Behavior, University of California, Irvine
**Peruvian Healing Sessions**

Fred Katz, a musicologist and I prepared an article for the American Journal of Folklore (1971) in which we transcribed some of the ayahuasca tapes that de Rios had gathered in urban Mestizo healing sessions in Iquitos, Peru. Healers were adamant about the importance of music in the healing session, and the role that melody played in programming the actual content of the vision in their “icaros,” or chants calling upon familiares to help them to see the cause of illness (often witchcraft hexes) and to allow them to return the evil to the perpetrator so that healing could occur. Katz and I subsequently published a second article on music and drug-induced altered states of consciousness (1975). We argued that the anxiety generated by rapid access to the unconscious may be expressed in such symptoms as nausea, diarrhea, cramps, tachycardia and increased blood pressure. These components of the “bad trip” have been reported in all cultures for which adequate data is available. The pervasive presence of music as an integral part of the drug experience constitutes one of the most powerful rituals associated with the social management of altered states of consciousness.

Click here to listen to the healing sessions:

[Healing Session 1](#)

[Healing Session 2](#)

**“JUNGLE GYM”**

The participant in the ritual perceives the structure of music quite differently from the way he would perceive it during normal waking consciousness. We know, of course, of the mathematical precision and structure that all music possesses, whatever the musical tonal system of a given culture or the repetition of musical phrases involved. What Katz and I argued is that once the biochemical effects of the hallucinogenic
drug alter the user’s perception, the music operates as a “jungle gym” for the person’s consciousness during the drug state. Just like the playground structure that children climb upon, the “jungle gym” provides a series of pathways and banisters through which the drug user negotiates his way. Here we are using metaphorically the architectural structure composed of iron bars interlinked in horizontal and vertical planes. In contrast, however, to the child’s playtime structure, where the child can choose spontaneous pathways and heights to explore, we suggested that the companionship of music to the hallucinogenic drug experience functions almost like a computer’s software. It instructs the machine in a particular course to follow. The cultural patterning of hallucinogenic–induced visions suggest that the mathematical structure of music may serve specific cultural goals—to allow the drug taker to see the guardian spirit of the ayahuasca vine, to achieve contact with a special supernatural deity, and so forth. The music is imposed upon the drug user by the shaman, who controls to some degree his client’s visual options within this ritualized use of music.

**FREQUENCY**

The lowest common denominator of the musics appears to be the frequency of rattling effects, or rapid vibratory sounds, almost always in consort with whistling or singing. Rattles, singing, chanting and vocal productions in general, may be a very important part of the hallucinogenic experience in that the “jungle gym” is built up, torn down and rearranged in a sort of “block-building” of consciousness to serve specific cultural goals.

**SYNESTHESIA**

Synesthesias are commonly reported by drug users. In most tribal and third world societies where drugs are used, this scrambling of sensory modalities is not only recognized but actually underpins the program-
ming of rituals so as to heighten all sensory modalities. That would include visual, olfactory, tactile, auditory and gustatory senses.

**LSD and Psychotherapy**

Most recently, I have published a book, *LSD, Spirituality and the Creative Process* (2003), based on LSD research from 1954-1962 conducted by the psychiatrist, Oscar Janiger, when more than 930 people in Los Angeles were given Sandoz LSD experimentally. While the aim of the experiment was not to validate psychotherapeutic benefits of the LSD, a large subset of more than 225 people who were then in therapy, were given a moderate dose of LSD. Included in the sample were artists and musicians. One world-renowned musician reported the following effects:

“My flesh is charged with emotional responsiveness to the Mozart E-flat symphony. My skin seems microscopically thick and porous so as to admit the music more easily. The inner lines of counterpoint are suddenly so clear. The dissonances are so penetrating and the bass-line is positively alive. It jumps and strides with a kind of cosmic purpose. I am very sensitive but my real emotions still have not been engaged.

…My listening is extremely acute. (He listened to Mozart, Bizet Symphony, Moussorsky Pictures, the suite from Strauss’ Der Rosenkavalier and his own incident music.

My reaction to these pieces began with the conventional response but gradually took on a new character. It was as though the remaining ecstasy that flowed through me has washed away my patience with the exterior posturing of music. I felt that I saw directly into its heart and was interested only in what the music was really saying, remaining totally indifferent to how I was dressed. …The visual hallucinations were one of the more entertaining features of the afternoon. …I could not for a time distinguish between sight and sound. Later Mozart’s melodic line was filling the room. Later woodwind harmonies released ethereal glowing purples and pinks in shafts of radiant light which
streamed out from a picture in precise synchronization with the music. I felt that moment of incredible exaltation. I am, in this very instant, free from every petty negative emotion. I am devoid of anger, of jealousy, of fear.”

Conclusion

If these hallucinogenic substances are to be used psychotherapeutically in the future, the role of music as a primary conditioning agent of the experience will have to be taken into account. Any planning for psychotherapeutic intervention in times to come would necessitate a clear musicological approach to create therapeutic states of consciousness. Not discussed in this article is the work that Grob and I have done on suggestibility and the hallucinogenic substances (see Grob and De Rios 1996, De Rios and Grob 1994) which are also important effects of the hallucinogenic experience. Music can be a major mode of managing the drug-induced altered state of consciousness for therapeutic goals.

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Jazz, improvisation and a social pharmacology of music

Jörg Fachner

Abstract

Extending personal expressivity and relationship abilities during improvisation is a goal for active music therapy approaches. In creatively improvised music we hear how humans perform in the world and how the ‘sounding’ of their identity (Aldridge, 1996). Jazz music of the 20th and 30th has been dance music and musicians extended the structure of contemporary songs with improvisations (“embellishment”) during the played tunes. Vividly played improvisations, with a unique personal style and sound, made jazz musicians, their bands and live-clubs famous. Since the beginnings of jazz, the consumption of drugs and its relationship to creativity and music has been controversial. Research on cannabis and music perception has shown that there are certain changes in perceptual and cerebral processing which influences performing and creating music. Music therapists working with drug-experienced clients report problems with clients and their drug-related history of music perception. State-dependent perceptual learning processes might resemble during therapy processes. This paper will describe cultural issues and features of drug-induced music perception.
A Social pharmacology of music?

Social pharmacology is a discipline of pharmacology, that focuses on the usage of drugs as consumption behaviour. These behaviours are observed and described in their social environments and are interpreted with pharmacological, sociological and psychological methods. The aim of this approach is to understand or describe patterns of use and resulting risk behaviour. This data leads to adjusted prevention and harm reduction strategies, mental health proposals or modification of law, as we are observing in the 2002 British debate on rescheduling cannabis as a class C drug. Class C includes drugs, that are not freely accessible, but allowed for prescription and recommendation to patients. Private use and possession of small amounts can be tolerated. Being caught with cannabis will in future be treated no more seriously than illegally possessing other Class C controlled drugs like sleeping pills and steroids. This mitigation of the Cannabis laws is what scientists have proposed since the La Guardia Report of the 1940es (Solomon, 1966) or even the Carter Administration in the late 1970s.

PARTY DRUGS

The practice of social pharmacology investigations might be a statistical description of drinking patterns of club visitors, that is, which drinks were ordered, how long they stayed, or a survey on rave party attendees and their consumption patterns of Drugs. Based on 1,853 questionnaires derived from adolescent students participating in a Canadian Student Drug Use Survey, Adlaf (Adlaf & Smart, 1997) described the prevalence of rave attendance and the drug-use profile of rave attendees. For two-thirds of rave attendees, drug use was significantly elevated. Although rave attendance is not prevalent, experienced drug users are attracted to raves, as earlier generations of drug users were attracted to rock concerts.
One study (Forsyth, Barnard, & McKeganey, 1997), with 1523 school children in Glasgow, aimed to find a relationship between the preference of music styles and drug experience. Although few children in this study had ever taken the drug ‘ecstasy’ (MDMA), fans of rave music were more likely to have used drugs than those who preferred other styles of music. This relationship held true across a range of drugs used, across two geographical areas, over time and controlling for age, gender and parental social class.

Why are concert and rave party attendees attracted by certain drugs? One answer might be found in the action of drugs that change perceptual styles and filters. Another might be found in the personality or identity performance of an individual who takes part in cultural activities or habits, or a third answer might hold true that drugs have been used at parties since early days of humanity. However, these two studies mentioned above seem to back up lay prejudgments about a connection between specific music styles and certain drug effects. Is it possible, as we know from musical preferences, that there is something like a social pharmacology of music? This means that certain drugs lead musicians to certain musical styles and performance because some musicians are more attracted by a specific drug? Let me cite Mezz Mezzrow, a Jazz Musician from the 1930s who became much more famous for his marijuana joints for friends like Louis Armstrong, Hoagy Carmichael, Thommy Dorsey or others than for his playing. But by the way, he was not a bad musician. This is how they felt about alcohol and music:

“We were on another plane in another sphere compared to the musicians who were bottle babies, always hitting the jug and then coming up brawling after they got loaded. We liked things to be easy and relaxed, mellow and mild, not loud or loutish, and the scowling chin-out tension of the lushbands with their false courage didn’t appeal to us.”
Besides, the lushies didn’t even play good music – their tones became hard and evil, not natural, soft and soulful – and anything that messed up the music instead of sending it on its way was out with us. We members of the viper school were for making music that was real foxy, all lit up with inspiration and her mammy. The juice guzzlers went sour fast on their instruments, then turned grimy because it preyed on their minds.” (Mezzrow, 1946 p. 94)

**DRUGS AND SOCIETY**

In 1998, the International Narcotics Control Board in Vienna released a report that pointed to rock musicians, their songs and lifestyle as a certain reason for increased drug consumption in the 1990’s. Their drug-related lifestyle had an impact on young people’s decision to take drugs.

“By far the greatest influence on many young people in developed countries, as well as in some developing countries, is the promotion or at least the tolerance of recreational drug use and abuse in popular culture, particularly in popular music. Some lyrics of songs advocate, directly or indirectly, smoking marijuana or taking other drugs and certain pop stars make statements as if the use of drugs for non-medical purposes were a normal and acceptable part of a person’s lifestyle. Popular music has quickly developed into a global industry. In most countries, the names of certain pop stars have become familiar to the members of almost every household. With such globalization of popular music, messages tolerating or even promoting drug abuse are reaching beyond their countries of origin”. (INCB, 1998)

One study, published by the US National Clearinghouse on Drug Abuse from 1999, researched the contents of popular films and song lyrics for drug related issues. After all mostly alcohol and nicotine have been mentioned, followed by cannabis including those lyrics that mention legalization issues (Roberts, Henriksen, & Christenson, 1999).

In April 2003 the US government signed a child abduction bill and attached the Rave-Act and the Clean-up act to this bill. Section 305 of the Clean-up Act stipulates that:

„Whoever, for a commercial purpose, knowingly promotes any rave, dance, music, or other entertainment event, that takes place
under circumstances where the promoter knows or reasonably ought to know that a controlled substance will be used or distributed in violation of Federal law or the law of the place where the event is held, shall be fined under title 18, United States Code, or imprisoned for not more than 9 years, or both."

Any concert promoter, nightclub owner and arena or stadium owner could be fined and jailed, since a reasonable person would know some people use drugs at musical events.

**JAZZ AND MARIJUANA**

Anyhow, the history of attributing rock and pop artists as drug mediators for young people, who would start to imitate a drug-poisoned lifestyle, goes back to the early days of the 20th century. Since the beginnings of jazz the connection between cannabis, music and creativity has been discussed controversially (Aldrich, 1944; Barber-Kersovan, 1991; Böhm, 1999; Boyd, 1992; Fachner, 2002a; Fachner, David, & Pfotenhauer, 1995; Jonnes, 1999; Mezzrow, 1946) and after all - politically exploited as Shapiro or Sloman explained (Shapiro, 1988; Sloman, 1998). Harry Anslinger, 1930s Head of the US Federal Bureau of Narcotics put more jazz bands in jail than he could count, as mentioned in an interview with David Musto (Musto, 1997). Famous musicians -as we can read in the list-were observed and some sentenced for possession of cannabis. In front of the US 1937 congress, Anslinger talked about ”satanic voodoo jazz” and those ‘reefer smokers’ that would make white women want to have “sex with Negroes”. Furthermore, he described smokers as being violent and insane. He was also ‘able’ to segregate between good and bad musicians. The good ones play notes as written down on a score but the bad jazz ones would add more notes in between what is written down because of using cannabis and satanic voodoo rhythms (Sloman, 1998). Anslinger obviously used the negative popularity of mostly black Jazz musicians to support his position.
So, what happened those days back in 1934? The New York based ‘Litary Digest’ reported:

“While whites often buy reefers in Negro night clubs, planning to smoke them elsewhere, sometimes they manage to gain entrance to a mixed-colour party. The most talked of reefer parties – excluding those of Hollywood – take place in Harlem. Early in the morning, when night club singers, musicians and dancers are through work, they gather informally – these affairs apparently are never arranged – and have a few drinks.

With their uncanny power for wheedling melody out of even the worst pianos, it isn’t long before the crowd is humming, softly clapping hands or dancing in sensuous rhythms that have never been seen in nightclubs. There is little noise; windows are shut, keeping the smell of smoking weeds away from what might be curious nostrils.

Nor there is any of the yelling, dashing about, playing of crude jokes or physical violence that often accompany alcoholic parties; under the influence of marijuana, one has a dread of these things. Sensuous pleasure is the beginning and the end: Let us enjoy pleasure while we can; pleasure is never long enough” – as Propertius put it.” (Digest, 1934)

Playing Jazz music, smoking cannabis and talking in jazz slang “can also be interpreted as a ‘way of life’ characterized by specific identity postures and social performances of the artist’s world, bohemians, the ‘night people’ etc.” concluded Curry in his participating observations of jazz musicians and their audiences (Curry, 1968: 238).

What becomes obvious in these lines is that there is a connection between a certain lifestyle, identity, time and place of listening to and creation of music. This is what many of us as music therapists experience in our work with clients as well. Personal history and lifestyle lead to an individual form of performed identity expressed in the preference of a certain music marking passages of personal experience.
Psychedelic drugs – and cannabis has mild psychedelic effects - are preferably consumed in a setting suitable for the interaction of consumer and environmental cues to temporarily expand psychic reality. In certain psychotherapeutic approaches an attempt is made to stimulate and evoke unconscious material for psychoanalysis. Psychedelic therapy used music and fantasy themes as support and guidance in the psychedelic setting. The beginnings of “Guided Imagery in music” were based on such an aspect of psychedelic therapy. Certain pieces of mostly classical or jazz music were conducted in a thematic therapeutic sequence to facilitate emotions, evoke peak experiences, uncensored responses and associations and to open a path to the inner world of the client’s unconscious. All this happened in a relaxed secure and guided setting of psychedelic therapy. Anti-toxicants for a possible bad trip were at hand and therefore the patient could let go (Bonny & Pahnke, 1972). However, the rising subculture of hippies transferred core elements of psychedelic therapy into cultural symbols, and musicians went on stage to create public trips into sound as an acoustic surrounding for the ‘pot- and acidheads’ on their ‘trip’ into inner and outer space. Here, music was also used and created as a guide to keep the acidheads ‘on track’ during the hallucinogenic state.

Early research on music and drugs was published as basic research on music perception, production and therapeutic use (Bonny & Pahnke, 1972; Eagle, 1972). One research project published in the German area of music therapy done by Weber in the 60's focussed on the use of psilocybin, a fungus with psychoactive ingredients (Weber, 1974). His work was in the tradition of model psychosis research. The method of a model-psychosis was invented to compare psychotic states of hallucinations with drug-induced hallucinations and to discuss its noetic and clinical considerations (Gouzoulis-Mayfrank, Hermle, Thelen, & Sass, 1998; Leuner,
1962). The aims of this approach are to describe pathological states like
the productive states of schizophrenia, which seem to be analogous to
some experiences made during psychedelic drug action. In Weber's
research a drug-induced altered music perception should serve as a model
of functional regression to lower levels of cognitive development.

Research on state-dependent effects of music on mood and behaviour
referred to individual perceptual learning strategies and history under the
influence of drug action (Globus, Cohen, Kramer, Elliot, & Sharp, 1978;
Thaut & de l'Etoile, 1993). State dependent recall of mood and situated
cognition is hypothesized for the efficiency of music therapy with
Dementia and Alzheimer’s Disease patients. Music reactivates memory
processes instates no longer accessible by normal daily activities (Ald-
ridge, 1996).

Research with psychoactive substances and music perception might help
to show models of neuro-physiological functions of state dependent
recall and cognition. Currently a research group is working on the neuro-
physiological exploration of fantasy systems using results from psyche-
delic research (Emrich, 1990; Leweke, Giuffrida, Wurster, Emrich, &
Piomelli, 1999). In recent animal studies a new brain system -the cannab-
inoid receptor system (CBR)- has been discovered in the brain, and the
immune system. This discovery has gained a lot of new research and
offered new treatment strategies for Multiple Sclerosis, Alzheimer’s Dis-
ease, Glaucoma, Nausea, Tourette syndrome, Schizophrenia, etc. The
interested reader is forwarded to the textbooks and overviews published
(Grinspoon & Bakalar, 1997; Grotenhermen & Russo, 2002; Solowij,
1998).

Music therapists working with drug-experienced clients, suffering from
addiction report problems that they have with music perception and
altered states. (See article from Tsvia Horesh in this issue). State-dependent perceptual learning processes might resemble processes occurring during therapy. We can imagine that once a client has experienced a way of life involving states of drug-use, than emotional aspects of memory will be reactivated when certain cues are heard in the music, or during movements in dance, and this may interfere with the aims of therapists. Such problems are not ‘in the music’ or the substance itself, but connected to the brain reward system, which is linked to perceptual learning and habituation of emotional states like euphoria, flow, joy or pleasantness. Drug-induced positive moods and states of euphoria, music-making or listening or other pleasing activities like eating, sex or play is mediated through the brain reward system (Blood & Zatorre, 2001; Lukas, Mendlson, & Benedikt, 1995; Wise & Bozarth, 1985). Patients with a history of drug-induced euphoria may experience a state-dependent recall induced from certain individually perceived cues, which have been experienced together with drugs. The connection of joyful experiences intensified by drug action is producing a strong memory account and craving for such situations might lead to an addiction. Hereby the addictive potential of different drugs and their specific pharmaco-kinetic and -dynamics (Julien, 1997) has to be taken into account. These learning processes have to be focused and transformed in therapy by offering new ways of experiencing.

HABITUATION AND LIFESTYLE

Becker in his classic sociological deviance study of Marijuana use among jazz musicians was able to show that recognizing and enjoying the effects has to be learned (Becker, 1963). Jazz culture preferred the euphoric plateau of cannabis action, the period of laughter (Siegel & Hirschman, 1985) and emotional enjoyment, because it made them ‘hot’ to play, their auditive impression on music was enhanced and they improvised more expressively (Curry, 1968; Shapiro, 1988). Hippie culture seemed to be
more interested in the second phase of contemplation and visionary state, as Baudelaire described the three stages of cannabis intoxication in the midst of last century (Ch. Baudelaire, 1988). After all the third phase of vivid hallucinations - as Ludlow wrote (Ludlow, 1857) - depends on high doses (Ames, 1958) and a certain set and setting (Blätter, 1992); therefore the third stage is drowsiness and sleep. The typical behaviour of the stoners in the second and third stage created the term of ‘being stoned’, (remember Bob Dylan’s famous verse “everybody must get stoned”). ‘Stoner’-cultures as well as the oriental and Chinese opium smokers preferred to contemplate, being in the orientalistic state of ‘khīf’, as referred to in the use of hashish as an intensifier of music perception and production (Gelpke, 1982).

In his book entitled „Drugs and Rock’n Roll“, Shapiro advocates the thesis that each popular music style in this century was also the expression of a certain life style, to be seen as related to the preferences in drug consumption on the part of the artists and the scene around them who coined this style (Shapiro, 1998). From a socio-pharmacological view, the preference of a subculture for a certain drug has always been a kind of fashion to “turn on”, i.e. to put them into certain physiological conditions in order to experience ordinary and extraordinary events, occurrences and moods more intensively and from a different perspective.

“…the opinion that under the influence of marijuana you can make better jazz since you lose your inhibitions and get better ideas and more self-confidence was common among the jazz scene”. (Shapiro, 1988 p. 38)
Drug action and improvisation

The Anslinger papers, which contain many notes about drug use among jazz musicians of the 30es, contain the following report about an arrested musician in the early thirties:

“This man has confirmed that the consumption of marijuana among musicians, above all those playing in so-called “jazz bands”, is wide-spread, since under the influence of the drug they seems to attain a certain gift which they do not normally possess. In the words of the individual mentioned before: they become hot (Shapiro, 1988 p. 63).

The term “hot” coined in this context describes an attitude and musical mood with a euphoric emotional quality and “an excessive heat of expression” (Behrendt, 1974 p. 20). Being hot meant being good, being expressive and flexible in the music and in general embodying a progressive attitude and approach. In the words of Behrendt:

“You do not really ‘play’ on your instrument but rather ‘speak’ through it...” (Behrendt, 1974 p. 20).

By the way, doesn’t it remind us of what music therapists hear in the form and quality of patient’s improvised play? More the form and communicative aspect of what and how it is played rather than the way it is judged from a technical stance? This jazz root of improvised music serves as an essential blueprint of music therapy work, as it offers a diagnostic tool for the therapist for listening after the session and for the patient as an expression of his musical identity.

But, is it true then, that the emotional quality of the individual musical expression was enhanced with marijuana. In another of Anslinger’s quotations, which has the negative connotation of musicians keeping themselves awake with marihuana, there is an implicit indication here to the first phase of intoxication induced by marihuana, character-
ised by euphoria and laughter, as Baudelaire described it (C. Baudelaire, 1966). Chemically synthesized marihuana was developed by Adams, a researcher at Anslinger’s laboratories, and introduced in the treatment of depression as an antidepressant and euphoretic called “Pyrahexyl” (see Behr, 1982 p. 204; Stockings, 1966). This euphoretic and energizing element of the effects of marihuana seemed to be the favourite effect at that time, and highly appreciated by musicians in tendentially faster music. It is interesting to note that the term “jazz” – according to Behrendt – was derived from the dialect or jargon expression ‘jass’, ‘jasm’, for ‘speed’ and ‘energy’ in sports and games and sometimes also used with sexual connotations as ‘gism’ (see Behrendt, 1974 p. 21); the term thus stands for a description of temporal processes and intensity.

With inhibitions falling away, one might of course be tempted to try out things one would not have dared before. However, John Hammond e.g. complained that marihuana “hellishly interfered with the sense of time” (in Shapiro, 1988). Becker quotes a musician on his cannabis experience in the music:

”We played the first tune for almost two hours – one tune! We got on the stand and played this one tune, we started at nine o’clock. When we got finished I looked at my watch, it’s a quarter to eleven. Almost two hours on one tune. And it didn’t seem like anything. I mean, you know, it does that to you. It’s like you have much more time or something.” (Becker, 1966: 74)

**TIME EXPANSION**

However, all kinds of processes occur in time. We are ‘patterned frequencies in a matrix of time’ improvising our identity in the personal set and setting of situations we’re in, as David Aldridge has proposed (Aldridge, 1989). In the experience of time as *kairos*, time structures are connected to the personal time. Time as *chronos* is connected to processes concerned with defined geographical and societal agreements. Kairological time allows a variety of time perceptions and refers to the right time to do
something, to decide or act directly in the here and now. A talk can seem like hours, even if it lasts only 20 minutes or it can be exciting and feels like only a few minutes. There must be specific moments, situations and interests that interfere with a personal kaiological set of emotions, habits and attitudes. We need specific settings and surroundings that make us experiencing an event as acceleration (‘rush’) or a slowing of time.

Cannabis influences this personal set of time frames. There is a feeling of time being stretched or expanded or perceived as slowed down or sped up. 95% of 151 participants of Charles Tart’s study “On Being Stoned” agreed to the following statement:

“Time passes very slowly; things go on for the longest time (e.g. one side of a record seems to play for hours)” (Tart, 1971).

In most experiments, stoned subjects failed to reproduce a correct metric counting of time intervals, and tended to expand the estimated units. Jones reported that a 15 second time interval was expanded to a mean of 16.7 seconds, with deviation up to 19 seconds estimated under the influence of oral THC, while being counted correctly in normal state (Jones & Stone, 1970). A reverse relationship also occurs. Melges declared a speeding-up of the inner clock as responsible for expanded and slowed perception of chronological time and for producing temporal disintegration failures.

“A subject becomes less able to integrate past, present and future, his awareness becomes more concentrated on present events; these instances, in turn, are experienced as prolonged or timeless when they appear isolated from the continual progression of time” Melges concluded (Melges, Tinklenberg, Hollister, & Gillespie, 1971: 566). This reminds of some of the counter-culture focus ideas on the ‘here and now’ feeling. Emotion-related time and information selection processes are co-
ordinated in the limbic midbrain, hippocampal and cerebellum parts of the brain, regions found to host high amounts of the recently discovered cannabinoid receptors (Joy, Watson, & Benson, 1999). Another brain imaging study of time perception correlated cannabis-induced changes of cerebral blood flow in the cerebellum (Mathew, Wilson, Turkington, & Coleman, 1998).

Assuming that this endogenous cannabinoid system is involved in time processing in general, the scope of this experimental research is not that far from research on time processes in music perception and its therapy. (See also the papers from U. Maas and M. Dobkin de Rios in this issue).

**RHYTHM**

If cannabis induces a subjective time expansion, music, and especially the rhythm must be perceived as expandable. In experiments Aldrich (1944) as well as Reed (1974) reported cannabis-induced changes on the rhythm scale of the ‘Seashore test’. Despite the controversy discussions about the Seashore’s usefulness, after cannabis intoxication rhythm was perceived more distinctly and especially casual users had an obvious improvement in the rhythm task (Reed, 1974). Most of Aldrich’s subjects – two of them musicians - said that they had the subjective impression of perceiving tones and rhythm better after cannabis intoxication.

Jazz musicians of the 1920s and 1930s had to play contemporary tunes the whole night for dancing, so an embellishment of song structures was needed to maintain interest and cannabis seemed to provide a nice inspiration to create a larger vision for doing this. With Marihuana, “The swing musician ascends new peaks of virtuosity” was written in a 40’s Life magazine article (in Aldrich, 1944). Cannabis’ first euphoric level seemed to help them to express vividly, intensive with self-confidence, groove and jive in the music, reported the psychiatrist Winick (C. Winick, 1959; Charles Winick & Nyswander, 1961). Jazz music featured
improvisational elements within the structure of songs. Musicians expanded the melodic, harmonic and rhythmic structure of dance songs in their improvisations. Dr. Munch, the physician in Anslinger’s team, said in a 70es Interview to Larry Sloman.

“... if you are a musician you’re going to play the thing the way it is printed on a sheet. But if you’re using marihuana, you’re going to work in about as twice as much music in-between the first note and the second note. That’s what made jazz musicians. The idea that they could jazz things up, lift them up...” (Sloman, 1998: 147).

Changed time estimation may thus temporarily permit an increased insight into the space between the notes, as if music is heard with a time lens but in real time. Urchs refers to the ‘space between’, as a noise ratio relationship between information units that enables us to generate new patterns (Urchs, 1986). This ‘insight’ might enable a skilled musician to preconceive arising melody lines with suitable harmonic changes over a certain groove of rhythmic structures. This kind of foresight due to a prolonged kairological time scaling in the flow of improvisation might open up a more vividly playing and intensity scaling of expressive elements. Vividly played improvisations with a unique personal style and sound made jazz musicians, their bands and live-clubs famous.

Anyhow, for Lindsay Buckingham cannabis seemed to work like a refreshing of his listening abilities:

"If you’ve been working on something for a few hours and you smoke a joint, it’s like hearing it again for the first time” (Boyd, 1992: 201).

George Harrison would have agreed with him:

"I think that pot definitely did something for the old ears, like suddenly I could hear more subtle things in the sound” (Boyd, 1992: 206).
Globus did another study that backs up this idea of a temporarily broader, extended perception of music elements.

Caldwell reported an increased sensitivity to intensity thresholds. Loudness parameter detection was enhanced. He couldn’t find cannabis-induced changes in basic auditory functioning of the outer and inner ear (Caldwell, Myers, Domino, & Merriam, 1969). Globus referred to Caldwell’s work and Becker’s conclusion (Becker, 1966) that cannabis effects are learned. He conducted a research design with three different groups. All of them learned how to adjust a loudness level of 800 mV (81 dB) sound level on a 610 Hz frequency. One group learned the loudness level in a ‘stoned state’, while the other groups learned the loudness level in a normal state. The task was to adjust the loudness only by an internalized imagery of the learned criterion tone. The last two groups smoked either a placebo or a THC-joint at a defined time period. After these two groups received the joint, they failed impressively in adjusting the loudness level. Only the marihuana learners stayed stable in their adjustment (Globus et al., 1978). As a result, Globus suggested an expansion of the auditory measuring units as responsible for the experience of an enhanced music perception.

**Conclusion**

It is a goal for active music therapy approaches to extend personal expressivity and relationship abilities during improvisation. In creatively improvised music we can hear how humans perform in the world and how they achieve identity (Aldridge, 1996). In an EEG study Fachner showed, that the EEG topography of music listening activity did not changed but exhibited more amplitude power on the alpha range when listening to music in an intoxicated state (Fachner, 2002b). The EEG
topographies of music listening exhibited inter-individually different EEG gestalts but were intra-individually stable. This means that music is perceived and processed inter-individually differently but intra-individually the listening strategy is linked to personality and the way music is perceived. This might serve as means for demonstrating electrophysiological objectivity for individual therapy indication and treatment. Furthermore, these individual differences become visible when comparing quantitative EEG (QEEG) Brain maps derived from combined single case studies. In a quantitative study with results gained from a bigger number of subjects these individual features would be averaged to a statistically acceptable profile but loose the important information as visible in individual topographic QEEGs and treated as visual phenomenological comparison of EEG-gestalts.

We can see that marihuana has a certain action profile, that has an impact on playing and listening to music while being under the influence of cannabis. Becker demonstrated that musicians were able to habituate to the cannabis effects (Becker, 1963) and used time expansion issues and emotional enhancement of intensity scaling (Globus et al., 1978) for their artistic expression. A reduction of inhibitions can offer a more direct way of emotional expression and this made jazz musicians hot in their playing (Shapiro, 1998). Jazz music has been one of the contributions to improvisational abilities of musicians and served as a tool which music therapists.

From the stance of modern receptor science, the external agent of cannabis docks on the internal endogenous receptor and stimulates the system more intensively. This shows that cannabis only works as an enhancer of what is already there and does not add something completely new. One will not be suddenly able to play an instrument without learning, but his preconceptions about what is possible and ways of perceiving
the acoustic field will be changed. When generations of users report that they can listen to sound more distinctly and that cannabis enhances their appreciation of music, why shouldn’t a patient benefit?

Some pioneering work on the use of psychoactive substances during music therapy done by Peter Hess and colleagues has shown that cannabis might work as an adjunct helper in therapy (Hess, 2002). One Alzheimer patient, receiving an oral dose, was able to concentrate more deeply on sound than before and was attending the therapy process with much more cognitive attendance than before. Cannabis might help to broaden and intensify state-dependent recall of music memory structures and situated cognition of emotional learning. Furthermore, as is known from medical research, cannabis has a neuro-protective function, which hinders free radicals from destroying nerve cells. Here, the pharmacological action of cannabis might be usefully combined with processes initiated in music therapy.

Perceptual filter lowering of psychedelic drugs was used in the beginning of GIM to evoke a free flow of associations in psychotherapeutic context. Helen Bonny always stressed that the use of drugs was not really needed for doing guided imagery in music but in a personal communication she agreed that the levels of emotional involvement were different with or without substances and so was the flow of ideas and associations.

A social pharmacology of music might help us to understand the use of drugs in certain contexts of music activity. The use of drugs is predominately reported in the context of addiction. However, there is a culture of using drugs in medical, psychological, traditional and cultural settings, which is not problem-related and uses drugs for certain purposes (see Blätter, 1990) as outlined above (see De Rios and Maas in this issue). For music research, these cultures are of interest because they help to under-
stand ways of perceiving and processing music in different states of consciousness.

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Dangerous Music - Working with the Destructive and Healing Powers of Popular Music in the Treatment of Substance Abusers

Horesh, Tsvia

Abstract

Addiction can be looked upon as a psychological or medical pathology, but it is also a cultural phenomenon and a culture in itself. In making the transition from the culture of addiction to the culture of recovery, the addict has to learn to deal with cues and craving. Music, for addicts, has powerful destructive and healing potential. It can be abused, as drugs are. It can be misused and lead one into a vicious circle of dependency and self-destructiveness. But music has the potential to heal. By assisting addicts in rehabilitating their music-listening habits, they can learn to face their dangerous music, and begin to incorporate music into their lives as a source of enjoyment and enrichment.

Introduction

The sirens of ancient Greece sang dangerous music. Nesting on a pile of human bones, on a rocky island off the coast of Sicily, the bizarre creatures, half bird-half woman, sang to the sun and rain; their song had the power to calm or to stoke the winds and to
inflame men's loins. Their music was irresistible, the words even more so than the melody. They promised knowledge to every man who came to them, ripe wisdom and a quickening of the spirit. Many a sailor was lured to their shore -- where he'd pine away without food or drink, unable to break the sirens' spell.

The sirens' music tempted sailors by offering an illusion of power, joy and wisdom. The music was sweet and seductive; the danger of losing one's connection with reality, even losing one's life, was apparent. But for the victims, the attraction was far more powerful than the concept of danger.

My clients are the modern-day sailors; the sirens can be seen as the drugs they abused for many years, substances whose sweet promises of joy, well-being and transcendental experiences were found to be deceptive, only after addiction overtook the last vestiges of control they had over their habit.

The sirens, actually, sang “dangerous music”. Many addicts talk about “using” music interchangeably with drugs, listening obsessively to music during periods of abstinence. Here, the symbolism of the sirens' music receives a duel meaning - not just the deceitful promise of the drugs, but, also, the powerful attraction of drug related music.

CLIENTS

My clients are chronic substance abusers, undergoing a yearlong, inpatient treatment program in the Ramot-Yehuda – Zoharim therapeutic community, in Israel. Men and women, aged 19-50, with a history of drug abuse lasting between 2 to 30 years. The majority have lived a life of crime and spent time in prison, usually as a result of drug abuse, selling drugs, thefts, violence and prostitution. Many come from multi-problem families, with a history of various addictions, life in crime ridden neighborhoods and easily accessible drugs.
Therapeutic Community

The basic ideology of the therapeutic community is one of inclusive, drug free, therapeutic care for the addict, as an individual and as a member of society. This ideology is based on the assumption that drug dependency is a mix of educational, psycho social, medical, emotional, spiritual and psychological factors, all of which must be addressed by treatment. It incorporates both psychodynamic and behavior-modification methods in an effort to relate to the complexity of the issues of addiction.

Addiction can be looked upon as a psychological or medical pathology, but it is also a cultural phenomenon and a culture in itself. The aim of treatment is to assist the addicts in leaving this culture and entering the culture of recovery. It is a long and difficult journey.

In his book “Pathways from the Culture of Addiction to the Culture of Recovery”, William White writes about the role the culture of addiction plays in sustaining addiction, regardless of the etiology that led to the initiation of the person-drug relationship. And, in the late stages of addiction, the culture of addiction can pose the largest obstacle for clients entering the recovery process.

CULTURE OF ADDICTION

The culture of addiction is a way of life: a way of talking, thinking, behaving and relating to others, that separates substance abusers from those who are not. The culture encompasses values, places, rituals, symbols and music – all of which reinforce one's involvement in excessive drug consumption. A particular client may have initially started to abuse drugs in order to deal with emotional trauma, but it is clear that his addiction has shaped every aspect of his lifestyle, and that all these aspects must be examined in the recovery process. Many addicts have found it...
easier to break the physiological relationship with their drug than to break their relationship with the culture in which the drug was used. The failure to break the cultural relationship often precedes relapse.

Some of our younger clients cannot perceive their social life without pubs, clubs and rave parties – all sites where drugs and alcohol are consumed, all ‘danger zones’ for the recovering addict. They cannot imagine going to a rock concert without taking - or drinking - something that will enhance their enjoyment of the music and enable them to feel part of the crowd.

Contemporary psychodynamic theories also recognize that much of the psychological dysfunction displayed by addicts is the result of drug abuse rather than the cause. It seems that some aspects of personality disorders apparent in addicts' behavior have developed secondarily as a consequence of substance abuse, whereas others are primary and stem from the interaction of early developmental wounds and experiences, with biological predisposition. (Kaufman 1994). The addict is a person with an unstable personality without inner sources to deal with daily pressures. The drugs enable him to deal with frustration, to disassociate from an oppressive and demanding reality.

**CUES AND CRAVING**

In making the transition from the culture of addiction to the culture of recovery, the addict has to learn to deal with cues and craving. Exposure to environmental cues associated with drug use can trigger cravings that cause cognitive and physiologic changes - increased thoughts of using and feelings of anxiety.

In the early stages of treatment, each client is encouraged to begin to identify his high-risk relapse factors - the personal cues, the “people,
Music and addiction


places and things“ (as coined by the Narcotics Anonymous groups) associated with his substance abuse. High risk factors can include:

- PEOPLE: active addicts, family relationships with elements of codependency;
- PLACES: where drugs are sold or used, personal haunts, neighborhoods and streets associated with use,
- THINGS: drugs and the equipment used for consuming them; films, literature and music that either promote drug use or are personally associated with the experience of use.

Most addicts, in the early stages of recovery, experience strong emotional and physical pulls back to active addiction, and ambivalence to their commitment to recovery. During such a vulnerable stage, exposure to cues that can trigger craving, may start a process that, if not checked in time, can cause them to leave the treatment program and relapse to drug abuse.

The song of the sirens, at times of crises in treatment, can drown out the sound of reason, of the quest for life, and cause our “sailors” to sacrifice all their gains in the recovery process for the sirens sweet music.

Music and addiction

Let us put the recovery process to one side for a few minutes, and look at the relationship that people that abuse drugs have with music.

Many of my clients claim that they cannot live without music. They tell different stories regarding their experiences with music, the differences relating to divergent ethnic groups, age, musical preferences, drug preferences and personality traits.

There is the music that was listened to in adjunction with drugs (though some clients relate that they were usually so intoxicated they weren't
interested in music at the time). Many addicts talk about “using” music interchangeably with drugs, listening obsessively to music during periods of abstinence. Music fills the emotional vacuum they feel without drugs, drowns out overwhelming thoughts and emotions, eases their passage into sleep and energizes them on waking up in the morning. Clients also talk about using music to avoid feeling – when faced with emotional conflict. Relying on drugs for these capacities, for so many years, they are unable to cope without external help, and music fills that need.

James Lull (1987), in his book “Popular Music and Communication”, discusses similar topics - how listening to music can enable one to escape from personal burdens and tensions, stimulate fantasies and feelings of mental and physical ecstasy, and to alleviate loneliness. Music helps to establish, reinforce or change moods. Anger, frustration, depression, restlessness, aimlessness, self doubt - these emotions lead one to seek music that mirrors the emotions, in an effort to seek validation –which is usually lacking in the addict’s social milieu. Certain kinds of music are used to resist authority, assert personalities, develop peer relationships and learn about things parents and schools don't teach. These notions are applicable to adolescent addicts and also to older addicts whose emotional and social development were arrested at the developmental stage in which the addiction began, usually adolescence.

Some clients will listen to any kind of music. Others are experts in specific musical genres and will gladly explain what kind of music goes with each specific drug they used, and argue with their friends if one can really enjoy music while using heroin, and if so, at what stage of the addiction.

“DANGEROUS MUSIC”

The idea that music can be dangerous - came up in a conversation with some of my clients last year. To my (naïve)– question: what kinds of
They expressed relief that someone was interested in this acute problem, which had never been addressed in therapy programs they had attended in the past.

The following notes are initial thoughts regarding the concept of “dangerous music” and of possible therapeutic methods that can be utilized in rehabilitating the complex relationship that addicts have with music. The work is at a preliminary stage, and I am aware of the need for more research and clinical experience.

The music that was pointed out as potentially dangerous was, basically, of 4 different genres:

1. heavy metal
2. rap
3. Israeli Mediterranean music, a local genre of popular music
4. rave, techno and house.

Interestingly, many of the addicts describe an overlapping between their preferred musical styles, and their “dangerous music”. They are drawn to listen to music that can, eventually, endanger them.

In interviewing my clients on their preferred choices of music, some generalities arose. People from different ethnic groups prefer different kinds of music:

*Heavy metal and rap* are preferred by young immigrants from the former Soviet Union, most of who came to Israel 10 years ago or less.
Mediterranean music is the choice of addicts who are usually native born Israelis, whose parents came from Arab countries, such as Morocco, Yemen and Iraq.

Rave, techno and house are chosen by the majority of the younger clients, in their early 20's, regardless of their ethnic background. Much has been written about the “rave generation” - the mass parties, the “clubbing” culture, the music and drugs (ecstasy /MDMA and LSD). I have found that the danger such music holds for the recovering addict seems to be in a different category than the other genres. The lack of lyrics, the lack of performing musicians one can identify with, the cultural setting of such music – set it apart from other drug related music and raise different psycho-social issues. for the purposes of this paper, I will limit myself to describing the effects of heavy metal and Israeli Mediterranean music.

**HOW ARE THESE GENRES OF MUSIC CONNECTED TO DRUG ABUSE?**

**Heavy Metal.** We will start with heavy metal. I invite you to listen to the music, and discover, first, how it affects you.

Lean back, close your eyes and allow yourselves to flow with the music. Notice what emotions arise, what your body wants to do.

(*track 1*: excerpt from “Wasting my Hate” – Metallica/ “Load” 1996)

Whatever emotions aroused while listening to the music, most of us, hopefully, have the capability of dragging ourselves back to the reality, and the responsible behavior expected of us, in the current activity of reading a professional article. Many addicts don't have those capabilities, or they are not easily accessible. After listening to a similar song of the heavy metal group Metallica, I asked my clients to write down what feelings, memories and thoughts came up. They wrote:

- street fights,
• heavy drinking,
• I don't give a damn…
• fooling around,
• wild behavior,
• hiding behind masks,
• it calms me down,
• what am I doing here (in treatment).

The client who wrote that last remark said that while listening to the music, he had felt the impulse to get up and leave - the program, his gains in therapy, his hope of a new life. He was shaken at how fragile his recovery was.

Research done on the effects of heavy metal music on adolescents re- states some of my clients' reactions. Jeffrey Arnett (1996) interviewed adolescent boys on their involvement with heavy metal music. He found that some boys tended to listen to such music when they were in a negative mood and that the music had a purgative effect, relieving their anger. The music was “used”, like a tranquilizer, to relieve anger and to gain control. Other boys reported that when listening to the music with friends, it induced greater aggression, and put them into the mood to do violent acts. Arnett sees the popularity of such music as a symptom of alienation, the music being a reflection - and not necessarily the cause - of recklessness and despair.

Much of mainstream society's opposition to heavy metal, punk and rap music is related to the explicit lyrics, which include themes of sex, violence and drugs. It is interesting to point out that the majority of my clients do not know the English language and so can't understand the lyrics, apart from a few repetitive words. They relate, on the whole, to the rhythm, instrumentation, and general atmosphere of the song. I have also noticed that in many CD's of contemporary heavy metal groups, the
inserts do not always include the texts of the songs, but only sinister-looking images of the rock-stars. It is usually difficult to understand the lyrics from the singing itself. These facts raise questions of the relevance of the “explicit lyrics” to the listeners' reactions to certain kinds of music. Recently, though, I was introduced to the music of Marilyn Manson (the American group mentioned in the movie “Bowling for Columbine”). Some of my clients, young immigrants from Russia, identify with this music, and know enough English to understand the texts of the songs, which deal with issues such as drug abuse, violence, anti-christ and hopelessness. We are now at the early stage of dealing with the meanings of this music to their lives, their drug habits and their re-habilitation.

**Mediterranean music.** Let us move on to another genre of popular music that can be dangerous to addicts. Israeli Mediterranean music is a hybrid genre created in Israel by Jews from Arabic speaking countries. The music was, in the 1970's, thought to be culturally inferior by the mainstream, European-orientated culture and media. The music developed as an “underground” alternative, giving voice to the themes and musical heritage of the lower and working classes. The music is essentially either western music overlaid with middle-eastern ethnic “colors”, and the Arabic mellismatic form of singing, or authentic Turkish, Yemenite or Iraqi music with Hebrew texts.

The strongest connection the addicts have is with the sub-genre nicknamed “crying songs”. The lyrics and music of these songs evoke feelings of melancholy and despair. My clients relate that in times of depression, they are drawn to choose music that mirrors their mood, and while identifying with the words, and the memories the song evokes, sinking into feelings of self-pity and worthlessness. One man told the group that in the past, when feeling down, during periods of abstinence, he would listen to such songs alone in his room. His mother recognized
such behavior as a sign that he was on his way to a relapse. Another client related his repetitive pattern: he would choose a song that reminded him of his former girl friend, in order to evoke pleasant memories of their time together. While listening to the song he would identify with the lyrics, which usually spoke of abandonment and lost love. He would recall that, actually, his girl friend left him for someone else. He would then become overwhelmed with emotions of despair and hopelessness. His only way of dealing with these emotions was to block them out with drugs. Another client would turn the volume way up when listening to such music – so that his family and neighbors would know that he was depressed. It was the only way he knew to ask for help.

These are some examples of the ways addicts use – or misuse – music.

Looking back on our discussion of environmental cues and high risk factors, we can begin to understand the role music has as a component in the culture of addiction, and the so-called “danger” it presents in the transition to the culture of recovery.

The music stimuli evoke emotional and physical responses not just because of the music's properties, but because music recreates a mental and emotional representation of the essence of the moment when it was first heard. The memory evoked can be of negative experiences or emotions, or of actual drug use. The established links between certain types of music and the euphoric recall of drug intoxication, reinforced through thousands of repetitions, serve as powerful connections to the culture of addiction.

How can we understand the addicts' susceptibility to the sirens' call, why are they drawn to listen to music that they know can endanger them? And, how is music different from other high-risk relapse factors?
Addicts may choose to listen to certain kinds of music as an attempt at self-healing, as a quest for integration of past pains and experiences with their present life, or as a search for emotional and spiritual catharsis. They are used to turning to external factors to manipulate their mood and emotional state, using drugs and music, to this purpose, interchangeably. The drugs they used blocked out almost all emotional activity, bringing them to a state of, what they call “living dead”. Listening to music, they feel alive, connected to their past and present emotional repertoire. But something goes wrong, during what could have been a positive experience. The addicts' weak ego structure cannot deal with the overwhelming flood of emotional memories of pain, abuse and rejection. They figuratively “drown” in the oceanic feeling of regression, and reach out to the kind of acting they know best - substance abuse or risk seeking behavior.

In relating to the issue of dangerous music, in our music therapy groups, the first stage involves assessing the existence and intensity of musical cues from the culture of addiction. We explore the links between the clients' musical preferences and their drug-using identity and experiences.

The ancient Greeks had ways to deal with the sirens' dangerous music. Circe, the sorceress, advised Odysseus on how to deal with the danger when sailing by the sirens' island. She told him to order his sailors to plug their ears with bees wax, thus preventing them from hearing the music.

This is equivalent to the isolation techniques that involve protecting the client from exposure to the kinds of music that are so integrally bound to drug use that it is impossible to diminish its power as a conditioned stimulus. I believe that this technique is appropriate in the beginning stages of treatment, when the clients are just overcoming the physical stages of detoxification, and are experiencing withdrawal symptoms, among them an overwhelming flood of negative emotions. At this stage, clients are
usually not fully committed to their recovery and can be easily dissuaded by exposure to drug-related music.

In many inpatient treatment centers, this method seems to be the only technique in dealing with dangerous music. The music the clients are allowed to listen to is monitored by the staff, whose policy is usually to censor rave music and Mediterranean “crying songs”, because of their strong connection to drug abuse. No attempt is made to deal with the threat this music presents to the addicts. When the clients finish the treatment program, they are left to deal on their own with the sometimes critical effects such music may have on their emotional well-being.

Odysseus himself, feeling more privileged than his sailors, didn't want plug his ears. He wanted to hear the sirens' music but knew that he was not strong enough to hold back while listening to it. Circe suggested that he have himself tied to the mast, and to instruct his sailors not to heed to his pleas to untie him, when he looses his sense of danger under the influence of the music. On the contrary, they were to see his pleas as a sign that they must lash him even tighter to the mast.

Odysseus was willing to face the danger but both he and the sorceress knew that he needed external boundaries to contain his self-destructive tendencies.

By listening to each clients' dangerous music, in the safe, containing environment of the music therapy group, we provide the figurative “ropes”, tying the addict to reality, holding him from drowning in the music's emotional ocean. The client is encouraged to share, with the group, his memories and associations evoked by the music. Many times, people will disclose personal stories that they had not previously revealed in therapy.

But in order to enable the client to develop his own holding and containing powers, we turn to Orpheus for inspiration.
Orpheus, known for his creative, musical powers, found a way to deal with the sirens' music, saving his men and himself. Sailing by their island, he tuned his lyre and began to sing; and his persuasive voice overcame the allure of the Sirens. Vanquished, the Sirens from that moment lost all powers to do harm and were changed to rocks. One of them threw herself into the sea in vexation. Her body was tossed on to the shore by the waves, and a tomb was erected for her on the very spot where later the city of Naples rose.

GROUP THERAPY

In one of my group meetings, we attempted Orpheus's method in dealing with the danger the Israeli Mediterranean “crying songs” posed for the group members. I proposed that after listening to the song, we would improvise music that expresses the emotions evoked by the song. They chose to listen to one of the singers most identified with this genre – Ofer Levi, singing “The Road of Temptation”. The song has a Turkish melody, and was recorded during a live performance.

(\textit{track 2 The Road of Temptation, Words: D. Zigman, Music: traditional Turkish, Singer: Ofer Levi})

\textbf{MP3}

\textit{The Road of Temptation}

I pray to God, give direction to my life

I've lost control, the road tempts me.

I meet my friends, they're all talking about me

I've ruined my life, why, my God?

Yesterday I had everything, everything was beautiful

Today I'm alone, don't recognize myself

I had all I wanted, I lost everything
I got carried away by drugs

On a sunny, spring day my soul is cold

My heart is frozen, my love

I tried to talk, I wanted to tell you

About the bitter pain in my body

How long will I suffer?

I've broken my vows to you, God

**Listening.** While listening to the song, I could see from their body language that my clients were very moved, some of them showing signs of distress. When the song was over, I asked them to close their eyes, to stay with the emotions the music aroused, and to notice what memories it evoked. After a few minutes, I invited them to choose instruments. The transition from listening to the song, to choosing instruments and playing themselves, was not easy. There were feelings of unrest that led to talking and fooling around. I had to assert gentle authority and help them settle down, without losing the feel of the song. The instruments they chose were: guitar, Garmoshka (a small Russian accordion), 2 Darbukas (Egyptian drums), a wave ring, Domino, double cowbell. The guitar player has played professionally in the past; the rest of the group members have no musical experience, apart from 2 former improvisation group sessions. The improvisation lasted 7 minutes.

*(track 3 – Therapy Session Excerpt)*

**Beginning.** The beginning was tentative, even though the guitar played a constant rhythmic and harmonious base. The drummers had difficulty in staying with the slow, flowing rhythm of the guitar. I joined in with a
hand drum in order to stabilize the rhythm, feeling that it important to
guide them towards a stable rhythmic container. The eventual result was
an almost hypnotizing, repetitive flow of sound. I directed the entrances
and exits of the players. The domino kept a stable rhythm; the garmoshka
played a poignant melody.

**Group Discussion.** In the discussion that followed, I asked the group
members to relate to the emotions evoked by the song, and to their feel-
ings during the improvisation. The atmosphere was tense; some people
spoke about their painful memories, while other chatted with their neigh-
bors, laughed or fiddled with their instruments. Feelings of doubt, that
maybe the song took them so deep that there was no safe way out - began
to creep up on me. Soon there were outbursts of anger, insults and what
seemed to be a regression to behavior reminiscent of the culture of addic-
tion. This was not their usual behavior. The clients, having been in treat-
ment for 7-8 months, had, for the most part, internalized the behavioral
codes of the recovery culture. It seemed clear that the music we heard
was responsible for this regression.

When I asked what was going on, and shared my feelings with them, they
calmed down. One man said that this is how he behaves when over-
whelmed by negative emotions. I pointed out how easy it was to revert to
the addictive behavior, to the aggressive, disrespectful ways of relating to
each other, when exposed to music that reminded them of their past.

It's interesting to note that the improvisation itself was not sufficient to
purge the negative emotions evoked by the song. The aggressive behav-
ior began *after* the improvisation, and escalated while group members
were trying to share their difficult memories. The moment of recognition –
that this music not only affects their emotions but also controls their
behavior - was a moment of revelation.
The domino player, who had been the main aggressor minutes ago, said that he hates Ofer Levi's music, and tries to avoid hearing it. It brings up feelings of pain and anger that have been part of his life, since childhood. “I feel angry, but I'm not angry at any of you. There's no one that I'm angry at” he said. He apologized for his behavior and said that his rhythmic manipulation of the domino, accompanying the melodic music of the guitar and garmoshka, enabled him to express and release his anger.

The guitar player said that during the song, he could smell the rice his mother used to cook for him when he lived at home. He felt a wave of warm feelings for his mother, which surprised him. He said that he harbors a lot of anger towards his parents and feels ashamed of them. He was, during the past few days, even debating whether or not to invite them to the family therapy sessions which were going to take place soon. The positive memories of his mother challenged his conflict and ambivalence.

Regarding the aggressive atmosphere in the group, he said that if they had been active drug abusers, hearing that song, and if there had been a packet of heroin in the room - the result would be fist fights and stabbing. It was a miracle that they could channel such negative energy into improvising music.

The garmoshka player was a young man, whom I will call Tommy. He was known among his friends as a “clown”, his behavior characterized by much adolescent-like acting out. He said that the song took him back to the neighborhood he grew up in. He described a closely knit society, where the people all knew each other. Ofer Levi's music in the air, the women cleaning and cooking inside, the guys sitting outside, eating sunflower seeds and smoking hash. The atmosphere was one of potential violence and reckless behavior. The memory was nostalgic but tinged
with pain and fear, bringing up traumatic events from his past. He told us that the main emotion he felt was stress and unrest. In the past, when feeling this way, he would take a friend's car and drive it, recklessly … that was the only way he could calm down.

It seems that by merging with the guitar music, Tommy could connect with and express the sadness that was under the unrest and aggression he usually felt and acted on.

(track 4 Therapy Session Excerpt)

The song evoked a total reminiscent mode of being (smell, pictures, sounds, memories and emotions), and threatened to drown the people in an overwhelming emotional ocean. They responded by acting out their anxiety and negative emotions. Only after interpreting the connection between the song and their behavior, could they really look into the underlying emotions, and appreciate the purging and organizing effect the improvisation had on them.

Conclusion

In creating their own music, the group members had to adhere to the musical elements of time, rhythm, structure and dynamics, which required them to activate their ego capacities for focusing, relating to exterior boundaries and the behavior of others, decision making and concentration on the here and now. Into this structured container, they each brought their own personal pain, fear, love and anger. Joining with their friends, they created together a total musical experience, hopefully loud and strong enough to, at least partially, drown out the dangerous music of the sirens, as Orpheus did so many years ago.
My role in the process was similar to that of Circe, the ancient sorceress that advised Odysseus on how to deal with the sirens. Circe symbolizes one who knows the secrets and dangers of the unconsciousness. I, myself, am not endangered by the music we listen to, and am aware of the perils it holds for my clients. My duty is to initiate the encounter between the addicts and their dangerous music; to supply a safe musical/emotional container within which they can “face the music” and the emotional turmoil it evokes, and to guide them through the difficult encounter to a safe shore, to an ability to control their musical experience, rather than to be controlled by it.

Two of my clients, of their own initiative, have been working on finding an alternative musical repertoire for themselves, choosing music that is not connected to their drug abusing past. They feel empowered by this independent project and hopefully, the personal growth accomplished through the musical work, by way of mastering the experience of “dangerous music”, can be applied to other parts of their lives.

Music, for addicts, has powerful destructive and healing potential. It can be abused, as drugs are. It can be misused and lead one into a vicious circle of dependency and self-destructiveness. But music has the potential to heal. By assisting addicts in rehabilitating their music-listening habits, they can learn to face their dangerous music, and begin to incorporate music into their lives as a source of enjoyment and enrichment.

References


*Authors Address*

Tsvia Horesh M.T.

Ramot Yehuda Zoharim Therapeutic Community

ISRAEL

Tel./fax 972 2 5436 510

horeshfamily@hotmail.com

Music Therapy Methods In The Treatment Of Gambling Addiction

Erkkilä, Jaakko

Abstract

The music therapy methods mixed with other methods formed a combination that is suitable in many ways for the treatment of the gambling addiction. An approach with multiple methods makes the treatment flexible and varied, which facilitates the process of commitment. This is important with the gamblers who are typically impulsive and who often have problems in commitment. Having individual phases between the more stressful group process phases seemed to reduce mental stress and help the clients to continue the process. On the other hand, the study found places for improvement in the treatment program. Another aspect that has to be constructed carefully in future treatment programs is the group formation, which can have a large effect on the functioning of the treatment during the group phase. Finally, future studies should investigate the physiological effects of the PhA treatment in more detail, especially concerning the effects of music and music therapeutical methods.

About the nature of gambling addiction

Gambling addiction is the fastest growing addiction today (Horn, 1997). Depending on the way the problem is defined the amount of pathological
gamblers has been described to be 1-4% of the population. In DSM IV\(^1\) (American Association of Psychiatry, 1994) gambling addiction is defined as an impulse control disorder. Signs of the pathological gambling are various. Like drug abusers, also gamblers develop tolerance. They have to spend increasing amounts of money and take higher risks in order to get gratification (Gowen & Speyerer, 1995). When a pathological gambler pays all his/her attention to gambling it usually means that his/her life becomes absorbed only by gambling or by thinking about gambling. Pathological gamblers also tend to hide their problem as long as possible. It is typical that they lie to their family members or other close people about the losses and the debts (Pavalko, 1999). It is not rare that all the savings of a gambler’s family are lost because of the problem (Horn, 1997). According to Eadington (1997) gamblers become emotionally dependent on gambling and show the signs of weakened psychosocial functioning. In summary, pathological gamblers are suffering from many psychological and physiological problems: depression, increased suicide risk, aggression (which may lead, for instance, to domestic violence), anxiousness, stress-related psychological and physiological disorders and illnesses as well as from problems in human relations (see Gowen & Speyerer, 1995; Horn, 1997; Kramer, 1997; Pavalko, 1999).

Treatment program, participants and the types of data collected

The Finnish Association of Money Games (RAY), as a financier, and the Social Pedagogic Foundation, as the executor, planned and carried out a treatment program for those with gambling addiction. The whole treatment program consisted of multiple methods, including Physio-acoustic

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1. Diagnostic and Statistical Manual of Mental Disorders
method (PhA), music listening and painting, verbal individual and group therapy, and informative lectures. The authors’ role in the project was to study the whole of the treatment program including the client experiences and the effectiveness of the methods used as well as the success of the treatment in general. However, the emphasis of this paper is in evaluating the role of certain music therapy methods in the treatment of gambling addiction.

The participants of the study were 27 clients in three groups (8-10 clients in each group). The background information of the clients portray the clients as typical Finnish, the mean age was 36 years and their ages ranged from 25 to 66 years. However, the majority (70%) of the clients were men and a notably large number of the clients were unemployed or retired (52%). In order to concentrate on gambling addiction, an attempt was made to deselect people with multiple addictions for the treatment program.

The treatment programme consisted of four sequential phases that lasted about one year. The treatment program was designed to have individual and group phases alternating with each other. Phases are described below in the order they took place in the treatment program.

Phases 1 (Table 1) and 3 (Table 3) were individual sessions consisting mainly of the PhA treatment while phases 2 (Table 2) and 4 (Table 4)
were group sessions consisting of multiple methods including group music therapy.

TABLE 1. The goals, treatment methods and data gathered in Phase I.

<table>
<thead>
<tr>
<th>Collecting (Individual phase)</th>
<th>GOALS:</th>
<th>TREATMENT METHODS:</th>
<th>DATA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relaxation, Calming down, Pleasant experience Finding a suitable group Motivation for the treatment</td>
<td>Physio-acoustic treatment with music listening, individual verbal interview and discussion</td>
<td>Subjective self evaluation (client) Questionnaire (client) Blood pressure and pulse measurements (client) Notes (therapist)</td>
<td></td>
</tr>
</tbody>
</table>

In Phase I the main method was Physio-acoustic treatment together with discussion with the therapist who attempted to find out the nature of the problem of the client. In addition to the goals mentioned in Table 1, the therapist also tried to find out whether the gambling addiction was the primary problem of a client (which was the case in all the clients in this study), and whether it was that the client was participating in the treatment for other reasons. The Phase I consisted of four sessions which were held over a period of a few months up to five months.

The Physio-acoustic chair is a Finnish application which resembles the vibroacoustic method (see Skille, 1989, 1991, 1992; Wigram, 1996) in many ways (Figure 1).
According to Lehikoinen and Kanstren (1996) the Physio-acoustic device is a biophysical product. It is based on the utilising of infrasounds that are controlled by a computer. The equipment has been fitted into an ergonomically designed therapy couch.

Before and after each individual session with Physio-acoustic treatment the client was asked to write down his/her experiences by using specifi-
cally planned self-evaluation method and questionnaire. In addition, the therapist was asked to make notes from the session.

**TABLE 2. The goals, treatment methods and data gathered in Phase II.**

<table>
<thead>
<tr>
<th>Working phase (Group)</th>
<th>GOALS:</th>
<th>TREATMENT METHODS:</th>
<th>DATA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with the problem</td>
<td>Informative lectures, group discussions, group music therapy methods</td>
<td>Questionnaire (client)</td>
<td></td>
</tr>
<tr>
<td>Finding solutions, rational thinking</td>
<td></td>
<td>Material created in music therapy (texts, images, and paintings…)</td>
<td></td>
</tr>
<tr>
<td>Dealing with emotions</td>
<td></td>
<td>Notes (therapists)</td>
<td></td>
</tr>
<tr>
<td>Training ones own will</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with experiences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving self-esteem and self-knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Phase II was the first group phase. It was a combination of different psychotherapeutic models and methods such as psychodynamic and cognitive methods as well as verbal and music therapy methods. Music therapy was carried out as group therapy including music painting, music listening, relaxation exercises and discussion about the topics, emotions,
images etc. that arose from the music. The length of the Phase II was approximately two months and it consisted generally of 8 sessions.

**TABLE 3. The goals, treatment methods and data gathered in Phase III.**

<table>
<thead>
<tr>
<th>Maintaining phase (Individual)</th>
<th>GOALS:</th>
<th>TREATMENT METHODS:</th>
<th>DATA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To facilitate the ending the group phase II</td>
<td>Physio-acoustic treatment with music listening, individual verbal interview and discussion</td>
<td>Subjective self evaluation (client)</td>
<td></td>
</tr>
<tr>
<td>To motivate the client to continue the process</td>
<td></td>
<td>Questionnaire (client)</td>
<td></td>
</tr>
<tr>
<td>Training ones own resources</td>
<td></td>
<td>Blood pressure and pulse measurements (client)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notes (therapist)</td>
<td></td>
</tr>
</tbody>
</table>

The Phase III is based on the use of the same methods (both in the treatment and in the research) with Phase I. However, the goals of the phase are now different from phase I. The main difference is that in Phase III the emphasis is on the motivating the client to continue the treatment process and to assist the clients to cope with strong emotions often encountered in the previous group phase.
TABLE 4. The goals, treatment methods and data gathered in Phase IV.

<table>
<thead>
<tr>
<th>Developing phase (Group)</th>
<th>GOALS:</th>
<th>TREATMENT METHODS:</th>
<th>DATA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The responsibility of working as group</td>
<td>Informative lectures, group discussions, group music therapy methods, cultural activities</td>
<td>Questionnaire (client)</td>
</tr>
<tr>
<td></td>
<td>Strengthening the self</td>
<td></td>
<td>Material created in music therapy (texts, images, and paintings…*)</td>
</tr>
<tr>
<td></td>
<td>Training for the joining</td>
<td></td>
<td>Notes (therapists)</td>
</tr>
<tr>
<td></td>
<td>Training for the withdrawal from the treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consolidating everything that have been learned during the treatment thus far</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the Phase IV the treatment methods are mainly the same as in Phase II except of the method called “cultural activities”, which were activities such as visiting museums, concerts, theatres etc.

**Research methods**

The research was carried out as a combination of quantitative and qualitative methods. Qualitative data consisted of the notes by the therapists, open-ended questions by the clients and creative products originated in music therapy sessions (see Tables II and IV). All the textual data was analysed by the NUD•IST-software. Quantitative analysis was based on the questionnaires used in all sessions and also on physiological measurements taken twice during each session in individual Phases I and III. The
results from both methods were combined when interpreting the data, which is described next.

**Results**

The amount of gambling decreased during the treatment (see Figure 2 on page 10). The numbers on the x-axis indicate the frequency of gambling where 0 = “not at all”, 1 = “once between the sessions”, 2 = “twice between the sessions”, 3 = “three times between the sessions” and 4 = “more and the y-axis is the proportion of the clients. It is evident that the amount of gambling gradually decreases and in the final phase there is a significant number of clients who do not gamble at all. Despite this trend, few clients still gambled considerably at the end of the treatment program.
We will now describe some of the findings relevant to music therapy in detail. The questionnaires showed that the clients experienced the music mainly as useful tool in coping with the problem. Qualitative analysis revealed more details about this, indicating that the role of music was important in dealing with the strong emotions linked with the problem as well as describing the traumatic aspects of gambling by the symbolic means (images, paintings, stories etc.) stimulated by the music. More-
over, music tended to stimulate and deepen the discussion in some sessions where discussion seemed to be trifling or troublesome. Figures 3, 4 and 5 are examples of the symbolic means to deal with the problem that all have been created in music-painting context.

**FIGURE 3. “At the crossroads”**

Apparent in Figure 3 on page 11 is crossroads symbolism, which describes the two alternatives. If the client is able to end the gambling and stay away from it, a new car, a sailing boat, a summer house etc. are
available to him. If the client is not (and takes the lower road), the final outcome is very distressing: only gambling, murder, death etc.

**FIGURE 4. “Towards the sun”**

In Figure 4 one can find polarity which resembles the previous picture (Figure 3 on page 11). The blind alley on the left seems to be full of anxious themes. The drawer has written the names of the typical Finnish money games on the wall together with the words: “must”, “despair”, “sweat”, “rush” etc. On the right side of the picture the sun is shining and the caption in the bubble declares: “friends”, “close people”, “work”, “balance” and “joy” – the things that will not be reachable or enjoyable if one continues gambling.

By means of music the clients were able to create images associated with the problem. An example of this is given in the following quotation, which is a client’s statement after guided image travel with music:
“I was disappointed when you (therapist) said at the end that we should come back on the shore where we started the journey from. There, on the other side of the water, I would have had a new future. It would had been another one – without any opportunities for gambling.”

Earlier studies have found a connection between the stress-related problems and pathological gambling. Blood pressure and heart rate measurements as well as subjective self-assessments showed that the sessions with PhA treatment clearly reduced both self-reported (see Figure 5 on page 14) and physiologically measured (see Figure 6 on page 15) stress indicators.
FIGURE 5. Self-reports given before and after Physio-acoustic treatment (with music listening).

Self-reports given before and after FA-treatment

The Figure 5 displays the means of the clients’ estimations of their psychological and physiological well being given in the beginning of the session and at the end of the same session. The differences in all these questions were large and statistically significant. The physiological measurements (pulse and blood pressure) were in line with self-reports albeit the changes were not as clear (Figure 6 on page 15).
Although the pattern of results of the physiological resembles those obtained from the self-reports (Figure 5 on page 14), there were factors such as age, gender and physical fitness that could not be controlled thoroughly (due to a limited number of participants in this study) and hence the conclusion about physiological changes during the treatment warrant further investigation.

The analysis also revealed interactions between different mood ratings, amount of gambling and physiological measurements. For example, those who were classified as “high-gamblers” evaluated their moods consistently more negatively than those who were “low-gamblers”. An overall summary of the relationship between the mood and amount of gambling over time is portrayed in Figure 7 on page 16.
FIGURE 7. Amount of negative mood adjectives in relation to the amount of gambling in each phase.

The y-axis in the Figure 7 is the proportion of negative adjectives the clients reported and the x-axis is the amount of gambling. The mood ratings were obtained from a questionnaire, where the clients could choose from an array of 20 adjectives the ones that corresponded their mood. In the analysis, these adjectives were categorised into positive and negative and used as an overall indication of the mood. Figure 7 clearly shows that the gambling problem is related to psychological stress. It is interesting that in the Phase I, when the treatment process was at the beginning, high amount of gambling seemed not to be related to negative moods. When
the “real work” of therapy and the treatment starts from the Phase II (which was the first group phase), a high amount of gambling is already associated with negative moods. The adjectives chosen then were for instance “guiltiness”, “anxiousness”, “shame”. This pattern suggests that the treatment program made the clients well aware of their problem, which is vital for the success of the treatment.

Conclusions

The music therapy methods mixed with other methods formed a combination that is suitable in many ways for the treatment of the gambling addiction. An approach with multiple methods makes the treatment flexible and varied, which facilitates the process of commitment. This is important with the gamblers who are typically impulsive and who often have problems in commitment. Having individual phases between the more stressful group process phases seemed to reduce mental stress and help the clients to continue the process. On the other hand, the study found places for improvement in the treatment program. For example, the phase IV was too long, which resulted in few dropouts and lack of motivation. Another aspect that has to be constructed carefully in future treatment programs is the group formation, which can have a large effect on the functioning of the treatment during the group phase. Finally, future studies should investigate the physiological effects of the PhA treatment in more detail, especially concerning the effects of music and music therapeutical methods.

The main advantages of the music therapy methods were:

- Stress-reduction and relaxation (especially in individual phases where the Physioacoustic method was used)
- Providing a compensating pleasure experience (important when treating people with addiction problem)
• Extending of expression in non-verbal and in emotional areas (dealing with the problem through emotions, images, metaphors, associations and symbols)

• Stimulating speech

References:


**Authors Address**

Erkkilä, Jaakko

Email: jerkkila@cc.jyu.fi

Eerola, Tuomas

Email: ptee@cc.jyu.fi

Department of Musicology

University of Jyväskylä

BOX 35

40351 Jyväskylä

Finland

“How does British music therapy differ from Continental or American music therapy?” This question was prompted when I finished reading the introduction of the book ‘Music Therapy’ by Rachel Darnley-Smith and Helen M. Patey. These two experienced British music therapists would hopefully give an inside in the way British music therapists use music and improvisation during their treatments.

The first part of this introductory book to music therapy (“Getting started”) provides the reader with some background information about the history of music therapy in Great Britain. The second part looks into aspects directly related to the daily practice of music therapy.

The first part does not convince the reader in providing a comprehensive overview of British music therapy. For example, in the chapter about the most frequently used approaches, information on the analytical music therapy as developed by Mary Priestley is characterised as using both words and music, but does not look into the analytical aspect in any
details, nor why this is any different from non-British analytical music therapies. On the other hand, Creative Music Therapy as developed by Nordhoff (an American) and Robbins is described in much more detail (if you add up all the different fragments of the discussion of the model scattered throughout the book). Free Improvisation Therapy from Juliette Alvin, who is a well-known British music therapist, is left out of the chapter on frequented approaches without any justification.

What calls attention in the book is the short paragraphs. Sometimes it can be helpful to slice up complicated material into short pieces, in order to guide a reader towards a thorough understanding (like the separate notes of a score leads you to a beautiful melody). Unfortunately, this is not the case in this book. The paragraphs are not really related. They seem to be detached from one another and placed in a more or less logical sequence only later. The chapter about music and the therapeutic process suffers the same problem. Many issues are addressed just very briefly, and it is not clear whether they are of main importance or just slightly related. There is no distinct relation between the parts. It seems as if the authors could not decide which part was important to stress and which not. One wonders, whether this is the consequence of the approach towards music therapy the authors describe (pg. 45): “(...) we treat all events in a music therapy session as significant and potentially linked”.

In both parts of the book, improvisation is exemplified (although cross references to the different parts are missing). It follows that improvisation must be the most important aspect of British Music Therapy. Especially in the second part of the book (addressing clinical matters), the authors describe how improvisation is being used: “(Music therapists) intuitively use whatever musical sounds or musical resources seem to be
appropriate for a particular patient in that moment” (pg. 75). The cases, the authors present in the second part (Music therapy with children and with adults: Eight case studies) are vividly and well described. Unfortunately they have forgotten to connect them properly with the theoretical and historical parts they have outlined before these chapters.

A very brave chapter addresses the issues of working through setbacks during music therapy. The issues tackled here are highly recognizable for any music therapists (and hardly ever addressed in any music therapy literature!) For me this is a real British part; displaying honesty about limitations and problems one might encounter while working as a music therapist.

The last chapter of the book hands the reader all kind of British resources (British music therapists, researchers, authors, and journals) and information about courses, training etcetera. This chapter would better fit in the first part of the books and gives me the best answer on my first question. It provides me with some facts about music therapy in Great Britain, but lacks a deeper insight in its substance and background.

Author:

Laurien Hakvoort (MA, RMTh), Enschede Conservatory of Music, The Netherlands

Editorial September 2003

Hope you have had a nice summer holiday!

Three new editorial board members

First of all I would like to introduce three new members of our editorial board.

Dr. Marlene Dobkin de Rios, you might have read her article in our last issue, is teaching as Associate Clinical Professor, Dept. of Psychiatry & Human Behavior, University of California, Irvine. Marlene works as psychiatrist and counsellor and is an international expert on transcultural research and practice issues. Experienced as Editorial Board Member of several scientific journals we are lucky to have her with us.

Dr. Alenka Barber-Kersovan is affiliated with University of Hamburg in Germany, Dept. of Musicology. Alenka has worked as music therapist in psychiatry in Slovenia before she turned to musicology to do research on pop-music and gender issues. Research on popular music addresses similiar research problems to those that we have in music therapy and we are lucky to have her expertise as a music therapist and popular music researcher on our Editorial board.

Most of you will know Dr. Cheryl Dileo. She is Professor for Music Therapy at Temple University in Philadelphia, a former President of the
World Federation of Music Therapy, and works on several professional issues concerning music therapy all around the world. We are happy to have her and her experience in publishing scientific work as a member of our editorial board.

Odds and ends; themes and trends

A new development of "Music Therapy Today" will be a section called "Odds and ends, themes and trends". Tom Doch is a journalist based in Cologne, Germany and is engaged in the Science Network Man and Music in Austria (http://www.mensch-und-musik.at). He is collecting information about research in music therapy from all over the world. You might like to subscribe to his newsletter. He will compile a regular science news feature, giving short overviews of research projects and papers from around the world of music therapy.

THIS ISSUE

In this issue we would like to present some studies from the German music therapy research scene.

The first article "MAKS - A scale for measurement of expressive and musical behaviour" comes from Dorothee von Moreau.

Dorothee is a former editor of the German music therapy journal "Musiktherapeutische Umschau". Trained as psychologist, and working as music therapist in Frankfurt/Main, she has questioned the practice of listening to improvisations in music therapy and has developed a 7-point scale for the measurement of expressive and communicative musical behaviour in music therapy. Using video material from music therapy first encounter with ten different adolescent patients, the scale was evaluated by 52 raters with observations taken at two different times.
Findings on objectivity, reliability, differentiation potential, homogeneity and factor structure are presented, first applications are introduced. As we move on in the development of music therapy research methods, we need observational tools for the assessment of clinical material, particularly when clinicians are increasingly videotaping their work. Her doctoral studies at the University of Witten Herdecke are extending this work further.

Anne Kathrin Nickel and her colleagues, who contribute to the article "Music therapy in the treatment of children with migraine", are working at the German center for music therapy research in Heidelberg. Her article presents the first results on a research project on migraine.

Migraine in childhood is a serious health problem with a tendency towards chronification. According to the bio-psycho-social model, migraine is considered a disorder that is generated by multiple factors requiring an interdisciplinary treatment concept consisting of medical and psychotherapeutic interventions. Music therapy as a nonverbal, creative arts therapy is especially apt for the treatment of children. A specific music therapy treatment concept for children with migraine, which is designed to be executed within a multidisciplinary framework, is presented in this article.

Simon Gilbertson and David Aldridge introduce some Strategies for searching electronic databases. In this paper they share our experiences made in searching the literature during the first stages of a Structured Review Project. They give a suggestion for an optimal search-strategy and conclude with a quick reference checklist for use in designing and planning future literature searches.

Birgit Gaertner and Almut Seidel introduce their "Music Therapy in Psychooncology - A Gender Comparison Research Project" at the University of Applied Sciences in Frankfurt/Main. Their aim to find gender differences in the treatment of cancer opens a new field of research and insight into a well-known topic. We hope we can bring you more details and results when they are finished.
Julie Sutton is the Editor of the "British Journal of Music Therapy" and the current head of training of the Nordoff/Robbins Music therapy program in London. In her conference report "Dancing in the dark - some thought about a research symposium", she tells us about her impressions of the 2nd Research Showcase in Witten, Germany.

Last, but not least, we would like to remind you on the 6th European music therapy conference in Jyväskylä, Finland 2004. We have listed all details of the conference in the Call for papers. "You will find all updates and informations about the conference under the conference button on our homepage www.musictherapyworld.net."
Odds and Ends - Themes and Trends

collected by Tom Doch (Science Network Man & Music http://www.mensch-und-musik.at)

Music Therapy Strikes a Chord With Cancer Patients

Source: http://www.urmc.rochester.edu/pr/News/news.cfm?ID=336

Music therapy for patients who have undergone a bone-marrow transplant reduces their reports of pain and nausea and may even play a role in quickening the pace at which their new marrow starts producing blood cells, according to a pilot study to be published later this year in *Alternative Therapies in Health and Medicine*.

The study, led by O.J. Sahler, M.D., at the University of Rochester Medical Center, was done with 42 patients on the bone marrow transplant unit at the James P. Wilmot Cancer Center.

Students studying at nearby Nazareth College provided music therapy to 23 patients after their transplants, while 19 control patients received stan-
standard follow-up treatment. Patients ranged in age from 5 to 65 years of age; most were being treated for various types of cancer, including leukemias, lymphomas, and solid tumors.

The patients who met twice each week for music-assisted relaxation and imagery reported significantly less pain and nausea. On average, they rated both their pain and nausea severe before sessions, but moderate after sessions.

Their new bone marrow took hold faster, too: The average time until patients began producing their own white blood cells was 13.5 days in the group receiving music therapy, compared to 15.5 days in the control group. The length of this span of time, when patients are most vulnerable to infection, is crucial.

In some medical settings, such as mental health services, music therapy has been used widely to decrease patientsí perception of pain, anxiety and depression, and boost their feelings of relaxation. Itís also used in hospice to comfort terminally ill patients. But itís not commonly used with bone marrow transplant patients, who are often hospitalized for a month or more. Because their immune systems have been wiped out, visits are kept to a minimum to avoid infections, and feelings of isolation often set in. Patients can have a variety of side effects, including pain, nausea, fatigue, anemia and dehydration.

One reason we began this study was because patients were requesting new ways of treatment, says Sahler, a behavioral pediatrician who works with children who have chronic and terminal illnesses. The patients told the staff, ëI know Iím about to go through a major challenge that will be very painful and isolating. What do you have to offer me to help me get
Music Therapy Strikes a Chord With Cancer Patients

through this? Music therapy was one answer. We originally began the study with children but quickly decided to enroll adults as well.

Sahler teamed up with Bryan Hunter, Ph.D., an associate professor of music and the coordinator of music therapy at Nazareth College and adjunct associate professor of pediatrics at the Golisano Childrenís Hospital at Strong, who has established music therapy programs in several hospitals.

Hunterís students visited patients at the Wilmot Centerís Samuel E. Durand Blood and Marrow Transplant Center, providing a range of music-therapy services.

Sometimes students simply brought and played music the patients requested; other times they helped the patients play music themselves, or write their own songs, or talk about a favorite set of lyrics. Patients were also encouraged to visualize a peaceful and joyful setting during each session.

The program has been very well received, says Hunter. When a program like this is first introduced, typically we get mixed reactions. Some in the health care field are skeptical at first. But when they see the positive effects on patients, they usually change their mind. And other doctors and nurses are excited when itís introduced they think itís a great idea right from the beginning.

An early problem with the study, Sahler says, was that staff members frequently turned the music therapists away, saying the patients were too ill.

Itís taken awhile for staff members to recognize that music therapy can be very helpful to people when they feel most distressed, Sahler says.
A recent study has found music therapy is beneficial in some cancer patients.

Nurses and doctors originally thought that the patient had to be playing an instrument or singing along, but passive listening or simply the presence of the therapist providing music itself can be therapeutic.

Now with funding from the National Institutes of Health, the team is conducting a larger study to check its results. In the current study, scientists will also measure the amount of medicine that patients receive for pain and nausea, and they'll monitor levels of the patients’ cytokines—molecules in the body that are key to helping a patient’s immune system establish itself after a transplant.

In addition to Sahler and Hunter, immunologist Jane Liesveld, M.D., medical director of the bone marrow transplant unit, helped direct the study.

OUTDOORLINK: Homepage Olle Jane Z. Sahler, M.D.
http://www.urmc.rochester.edu/gchas/s_f/sahler_o.htm

Alternative Therapies in Health and Medicine
http://www.alternative-therapies.com/at/login/index.jsp

A recent study has found music therapy is beneficial in some cancer patients.

MUSIC BY PRESCRIPTION
By Christine Haran

Source: abc-news 19. August 2003
http://abcnews.go.com/sections/living/Healthology/HO_musicrx.html
Imagine leaving your doctor's office with a prescription for a violin concerto rather than pills. While this might sound like you should drive right to the nearest record store and pick up some CDs, such a referral actually involves sessions with a certified music therapist.

Over the last decade, music therapy has been used to treat a variety of conditions, including chronic pain, nausea and depression and anxiety. It has also been found to improve cognitive function in people with Alzheimer's disease and other forms of dementia, and to provide comfort during the end-of-life process.

A recent study has found that music therapy is beneficial in cancer patients undergoing bone marrow transplant, an often-difficult procedure in which bone marrow is temporarily removed so that high-dose chemotherapy can be given.

Below, lead study author O.J. Sahler, M.D., professor of pediatrics, psychiatry, medical humanities, and oncology at Golisano Children's Hospital at Strong in Rochester, N.Y., and Rosemary Oliva, the music therapist for the study, explain what music therapy involves and how it eased the recovery of the bone marrow transplants in their study.

SAHLER: The American Music Therapy Association defines it as the prescribed use of music to achieve a predetermined goal. It involves music that is specially chosen by the therapist and the person who is receiving the music therapy to achieve a goal that they have determined they want to achieve.

There are many different facets of music therapy. It can involve listening to live or recorded music. It can also be about making music. You can
A recent study has found music therapy is beneficial in some cancer patients. Make music by playing a particular piece that you know or learn, or you can write your own music. The music therapist can also write music to go with words that patients have written. And sometimes the music therapist will ask people what their favorite songs are and do what we call lyric analysis. That will explore why a particular song resonates with the patient.

**WHAT ARE SOME OF THE SETTINGS IN WHICH IT'S BEEN USED?**

OLIVA: Music therapy has been used in various hospital settings, especially in psychiatry. It's also been used in special education, nursing homes, psychiatric facilities and correctional facilities.

**WHAT CAN A MUSIC THERAPY SESSION INVOLVE?**

OLIVA: Sessions are client-oriented, especially in the hospice therapy might be a way to help distract them from some of the painful experiences that they were having, including bone marrow transplant.

Meanwhile, there were requests for additional support from adult bone marrow patients to help them through what they understood was going to be a very trying and oftentimes uncomfortable procedure for which they might be hospitalized for a couple of months. We began to offer music therapy to the adults in the hopes of being able to make this a more permanent offering in our bone marrow transplant unit, and decided to conduct a pilot study to find out whether or not we were doing any good.

**WHAT DID YOUR STUDY MEASURE AND WHAT DID IT FIND?**

SAHLER: We were interested in whether music therapy, given two to three times a week for the duration of the hospital stay, had had any effect on the degree of pain or discomfort that people were experiencing. We chose two parameters that are very common in bone marrow transplant patients: pain and nausea. Before and after a session of about a half hour, we asked patients to express on a 1 to 10 scale how much pain they were
A recent study has found music therapy is beneficial in some cancer patients.

feeling and how much nausea they were feeling. And what we saw were some dramatic decreases in their reported pain and nausea.

We also looked at whether the patients who had been receiving music therapy derived any benefit immunologically. The immunologic marker that we chostal setting. I go into the room and find out how people are feeling and work with that. So if they're feeling nauseous, I might try to distract them from thinking about the nausea. I would have the patient select music, and then do what I call progressive muscle relaxation, where you're tensing and releasing your muscles from head to toe. Eventually we'll get to the stomach and maybe at that point they've forgotten about the nausea.

Some sessions involve guided imagery. There's actually a separate sub-school called the Bonney method of guided imagery with music. With that type of imagery work, a piece of music is played and the client is told to close their eyes and say whatever comes to them while the therapist guides them through it. So it's very open-ended; it's very much like a psychotherapy experience.

What I do is more of music-assisted guided imagery, where I'm giving patients specific images to think about rather than allowing that exploration.

SAHLER: The director of the Nazareth College Music Therapy Program here in Rochester wanted to introduce music therapy into a hospital setting and thought children with cancer might be a receptive population. Many of our kids who come in for treatments are here for days and sometimes many weeks and months. We were hoping that music was something called time-to-engraftment. And engraftment is the point at which it
A recent study has found music therapy is beneficial in some cancer patients.

becomes clear, through laboratory studies, that the bone marrow—which produces white blood cells that fight infection—is beginning to function. We found that people who received music therapy regained immunologic function faster than people who were not receiving music therapy.

During the bone marrow transplant process, people have virtually no immunologic competency; they are subject to all sorts of infections that can be life threatening. So if we can decrease the amount of time that someone spends in jeopardy, then that is certainly adding to the benefit of the treatment as a whole.

That study is going to be published in the fall in Alternative Therapies in Health and Medicine.

HOW MIGHT MUSIC THERAPY IMPROVE IMMUNOLOGIC FUNCTION?

SAHLER: In our study, we encouraged people to use music therapy for relaxation and stress reduction. We know from studies —mostly in animals but some humans — that music has an effect on an organ of the brain known as the amygdala, which is considered the seat of emotion. If you have a certain musical beat, you can actually watch brainwave frequency change in response to the music that is being played.

The amygdala has a lot of neuronal connections with the hypothalamus and the pituitary. And both glands have an effect on the adrenal glands. It's in the adrenal gland that cortisol, a stress reactant, is manufactured. When you have high levels of cortisol circulating in the body, you tend to be in sort of a fight-or-flight kind of tense state. Being in this heightened, hyper-alert state for a long period of time can become very exhausting.

But if you are able to slow amygdala firing, you can slow down firing to the hypothalamus and the pituitary, which in turn will slow down firing
A recent study has found music therapy is beneficial in some cancer patients.

to the adrenal gland and slow the production of stress reactants. When you're able to decrease the amounts of circulating cortisol, you facilitate production of immunologic agents. So that's the current thinking, neuroendocrinologically, of what might be happening.

OLIVA: Yes, we have had people who sign on and aren't quite sure if they're really going to like it. And typically, those who sign on are very satisfied with the intervention and glad that they participated.

SAHLER: Oftentimes, these patients are older men who aren't quite sure that this is going to be any good and their wives have perhaps taken the upper hand and said, "Yes, you will participate." Almost inevitably they come away from the experience one of our definite supporters. And it's just been marvelous to watch.

OLIVA: After finishing undergraduate or graduate level coursework in music therapy, there is a six-month internship process that you are required to complete, and then you take a certification exam through the Certification Board for Music Therapists.

IS THERE CERTIFICATION FOR ALL MUSIC THERAPISTS?

OLIVA: After finishing undergraduate or graduate level coursework in music therapy, there is a six-month internship process that you are required to complete, and then you take a certification exam through the Certification Board for Music Therapists.

HOW CAN PEOPLE FIND A MUSIC THERAPIST?

OLIVA: Ideally, there'd be a music therapist at each hospital. If there isn't a music therapist available, you can find one through The American Music Therapy Association, which has a Web site, www.musictherapy.org.

If there's a local university that has a music therapy program, you might contact the chair of the department. And oftentimes you will find music therapists in schools with special education programs.

OUTDOORLINK: O.J. Sahler, M.D
Evidence That Consonance Reflects The Statistical Structure Of Human Vocalization

Listeners of all ages and societies produce a similar consonance ordering of chromatic scale tone combinations.

Despite attempts to explain the phenomenon dating back at least to Pythagoras, there remains no generally accepted scientific explanation for this musical universal.

Working from the assumption that conspecific vocalizations are the primary source of the periodic sound energy to which humans are exposed, we obtained normalized spectra from 100,000 recorded speech segments. The statistical spectrum of human speech (i.e., mean normalized amplitude as a function of normalized frequency) predicts both the frequency ratios that define the chromatic scale intervals and the consonance ordering of chromatic scale tone combinations.

This evidence indicates that consonance judgments are wholly determined by the relative likelihood of the different possible sources of tone-evoking stimuli.

Email: schwartz@neuro.duke.edu

OUTDOORLINKS:

Chromatische Tonleiter

http://www.musiklehre.at/9_011.htm
Bottlenose dolphins can make out the many differences between a Mickey Mouse balloon and a bottle opener — just by using their echolocation system. They are able to pick up detailed information about an object, such as texture and surface depressions, a report in this week's Nature finds.

The results suggest that objects can be recognized directly, without being learned through association with other sensory systems.

The ability of dolphins to detect distant objects using echolocation is pretty impressive, but an understanding of the full sophistication of the system is lacking.

To address this issue, Heidi E. Harley and colleagues designed a set of object-recognition tests for a dolphin called Toby, a resident of Disney's The Living Seas aquatic environment and an old hand at such experiments. Faced with a choice of unfamiliar objects, the team found that the dolphin could single out a specific item using echolocation alone, after
having seen it just once previously objects in the water were blocked from view by a thin black plastic sheet through which the echoes could pass freely.

The findings indicate that dolphins are able to detect directly the detailed features of an object using echolocation, and that these features match up to their visual image of the same object.

**CONTACT:**

Heidi E. Harley (New College of Florida, Sarasota, FL, USA and Walt Disney World Resort, Lake Buena Vista, FL, USA)

Tel: +1 941 359 4328, E-mail: harley@ncf.edu

**OUTDOORLINK:**

NEW COLLEGE FACULTY/Heidi E. Harley

http://www.ncf.edu/Catalog/Documents/NewCollegeFaculty.htm

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**The theme of the Music Therapy Congress: From Lullaby to Lament**

In 2005, the Australian Music Therapy Association will host the 11th World Congress of Music Therapy in association with the World Federation of Music Therapy. This event brings together clinicians, researchers and educators from around the world.

It is held once every three years, and provides a unique opportunity to share the cultural diversity and richness of music applied for the preven-
This is the first time the event will be hosted in the Asia-Pacific region. The Congress will bring together diverse philosophies in the therapeutic applications of music. The theme of the Congress is Music Therapy: From Lullaby to Lament.

The theme of the Congress is Music Therapy: From Lullaby to Lament, which encompasses not only the lifespan of humanity, but the evolving music that accompanies the journey. This will be a meeting to embrace the full spectrum of research and evidence-based practice that is applied to clinical reality. There will be an emphasis on sharing the music within the process of music therapy.

The program will consist of papers, workshops, round table discussions and themed symposia.

More details about the program will be available in November 2003.

**Bird song on the brain**

Source: Nature press release for 7 August 2003

The discovery, reported in this week"s Nature, sheds light on how the brain is able to identify auditory signals.
Timothy Q. Gentner and Daniel Margoliash trained eight adult starlings to tell the difference between up to ten different songs made by other members of their species.

They then recorded the activity of single and groups of brain cells as the birds listened to familiar and unfamiliar tunes.

Specific cells, located in auditory brain regions, registered the learned melodies.

This pattern of activity may help starlings to recognize familiar songs.

Previous theories have suggested that auditory "objects" are processed through an interaction between networks of cells that respond specifically to the sound, and lower-level sensory neurons that are tuned to more basic information.

Timothy Q. Gentner and Daniel Margoliash conclude that single neurons and small populations of neurons represent learned auditory objects in the environment, and that their activity is shaped by the animal's behavioural experiences.

**CONTACT:**

Daniel Margoliash (University of Chicago, Chicago, IL, USA) Tel: +1 773 702 8090, E-mail: dan@bigbird.uchicago.edu
Early life experience on the development of memory functions

MUSIC TRAINING IMPROVES VERBAL BUT NOT VISUAL MEMORY

1 - year Longitudinal Study

Source: http://www.psy.cuhk.edu.hk/~aschan/projects1-3.htm

Experience affects the development of cognitive processing. Previous studies reported that adults (Chan et al., 1998) and children (Ho et al., 2000) with music training demonstrated better verbal but not visual memory than their counterparts without music training.

This specific improvement of memory was proposed to be related to the variation of cortical structure between musicians and nonmusicians in which the former group demonstrated a relatively larger left planum temporale.

To examine the causation effect of the results reported by these cross-sectional studies, the present study followed 3 groups of children for one year. The first group (n=17) did not have music training at the baseline, and had received one year training at the second testing (NMT-MT).

The second group (n=9) were receiving music training at the baseline, but had terminated the lessons for at least 9 months prior to the second testing (MT-NMT).

The third group (n=24) were children having music training at the baseline and retest levels (MT-MT).
Their verbal memory was assessed with the Hong Kong List Learning Test and their visual memory was examined with the Brief Visuospatial Memory Test-Revised.

The NMT-MT (mean = 15.63%) group demonstrated similar improvement in their verbal memory as the MT-MT (mean = 10.17%) group, whereas the MT-NMT (mean = -3.94%) group did not show improvement in their verbal memory.

Read more:

http://www psy.cuhk.edu.hk/~aschan/projects1.htm

**Lateralized cognitive processes and lateralized task control in the human brain.**


Institute of Medicine (IME), Research Centre Julich, 52425 Julich, Germany.


The principles underlying human hemispheric specialization are poorly understood. We used functional magnetic resonance imaging of letter and visuospatial decision tasks with identical word stimuli to address two unresolved problems. First, hemispheric specialization depended on the nature of the task rather than on the nature of the stimulus.
Second, analysis of frontal candidate regions for cognitive control showed increased coupling between left anterior cingulate cortex (ACC) and left inferior frontal gyrus during letter decisions, whereas right ACC showed enhanced coupling with right parietal areas during visuospatial decisions. Cognitive control is thus localized in the same hemisphere as task execution.

**OUTDOORLINK:**
Homepage Prof. Gereon R. Fink
http://www.fz-juelich.de/ime/ime_kognitive_neurologie/

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**Hypnosis doesn`t improve pain relief strategies**

source: Becky Ham/Health Behavior News Service/www.eurekalert.org
12-Aug-2003

Techniques like relaxation and visualizing a pleasant scene can take the sting out of mild pain, but adding hypnosis to the mix does not make such techniques more effective, according to a new report in Health Psychology.

Leonard S. Milling, Ph.D., of the University of Hartford and colleagues, compared five different behavioral treatments for finger pain delivered under hypnotic and non-hypnotic conditions.

Treatments included imagining a pain-protective glove, relaxing various muscle groups, picturing a warm summer day and reciting statements like: “I’ll make the pain less severe when it comes.”
Hypnosis doesn’t improve pain relief strategies

While all five treatments lessened the intensity of pain among participants, the hypnotic versions were no better than their non-hypnotic counterparts in reducing pain, even among participants who were highly sensitive to hypnotic suggestions, say the researchers.

The amount of pain relief experienced by all participants, regardless of treatment, was due in part to how much they expected to benefit from the therapy, according to Milling.

Shorter treatments were also just as effective as longer ones, an encouraging sign for their use in pain relief among patients who have a hard time concentrating or who suffer through multiple painful tests and therapies, like burn victims or cancer patients.

Milling and colleagues caution, however, that the study’s results may be limited.

“Our results may generalize more readily to acute clinical pain that is mild to moderate in intensity, like a finger stick, and less readily to severe acute pain or to pain that is recurrent or chronic,” they say.

CONTACT: Center for the Advancement of Health

Ira R. Allen, Director of Public Affairs

202.387.2829

press@cfah.org

OUTDOORLINKS: Leonard S. Milling, Ph.D

http://uhaweb.hartford.edu/psych/faculty3.html
University of Hartford

http://uhaweb.hartford.edu/

New findings from a Queen's behavioural expert in eye/hand movement provide the first direct evidence that our brain patterns are similar whether we are actually doing something or simply watching someone else do it.

It's an insight that could have significant implications for the assessment of people with various movement disorders such as some stroke victims, says Dr. Randy Flanagan, who conducted the study with Dr. Roland Johansson of Umea University in Sweden.

The methods employed in the study could be used to determine whether people with impaired movement control also have problems understanding and perceiving the actions of others. The answer to this question will have implications for both diagnosis and assessment.

"This helps to explain how we understand the movements of others," Dr. Flanagan says. "We perceive an action by running it at some covert level in our own system. An example would be when sports fans watch football on TV and move in anticipation of action on the screen."
Brain patterns the same whether doing or just watching

Although this theory is supported by previous neuro-physiological and brain imaging studies, until now there has been little direct, behavioural evidence.

Dr. Flanagan's findings are published this week in the current edition of Nature.

The study builds on earlier findings by other researchers showing that some brain cells fire not only when picking up an object, but also when watching an experimenter do the same thing. Rather than mere imitation, Dr. Flanagan believed that such neural activity was a way of understanding the action in anticipation of performing it.

The current Queen's study uses human subjects to examine patterns of eye-hand coordination when performing and observing a simple block-stacking task. The researchers discovered that, both in watching and performing the task, people's gaze pattern is the same.

When watching a task being performed, subjects don't simply follow the movement of hand and block with their eyes. Instead, their gaze shifts in anticipation of the next move, and the brain patterns mimic those of someone actually doing the task.

"These results indicate that eye movements while observing an action task are linked with parts of the neural processes for planning and controlling manual action," says Dr. Flanagan. "This may provide insights into how we learn to perform tasks by watching." Measuring eye movements in people while they observe skilled tasks will help us assess whether the subjects are learning the task, by determining whether their eye movements match those of the skilled performer, he adds.
Brain patterns the same whether doing or just watching

OUTDOORLINKS:

Cognition & Action Laboratory/Dr. Randy Flanagan

http://pavlov.psyc.queensu.ca/~flanagan/

Department of Integrative Medical Biology (IMB) Dr. Roland Johansson

http://www.physiol.umu.se/index.html
MAKS - A Scale for Measurement of Expressive and Musical Behaviour

Dorothee von Moreau

Summary:

There is a lack of specific and well evaluated instruments of measurement required for research and documentation in music therapy. The article introduces a newly developed 7-point scale for the measurement of expressive and communicative musical behaviour in music therapy (MAKS). Using video material from music therapy first encounter with ten different adolescent patients, the scale was evaluated by 52 raters with observations taken at two different times. Findings on objectivity, reliability, differentiation potential, homogeneity and factor structure are presented, first applications are introduced.

KEYWORDS: music therapy – research – nonverbal expression – nonverbal communication – assessment

When the National Association for Music Therapy NAMT was founded in the US in the 50es, music therapists were placed under the obligation to “apply music therapy scientifically for therapeutic purposes” (Benen-
zon 1973, p. 158). This demand for a scientific basis met with scepticism for a long time; today, however, clinicians pay much attention to research as well. There is much pressure to gain status within the health care system on the basis of scientific work; there are urgent questions how to substantiate what happens in music therapy so that others may understand. According to Rogers (1996) two fundamental issues still hold the attention of music therapy researchers: to develop appropriate research methods, and to explore the language used to describe music therapy in practice.

The literature on music therapy offers various approaches how to describe a patient’s musical behaviour. Qualitative approaches use description and content analysis to understand the significance of a patient’s musical expression (Langenberg 1995, Tüpker 1990, Weymann 1990, Hegi 1998), whereas in quantitative approaches the focus is on description and categorization of musical behaviour. Earlier studies on scales describe musical improvisations by patients either via exclusively musical parameters (Pechr 1996) or – in accordance with other descriptive systems commonly used in psychology (EWL: Jahnke & Debus 1971, EED: Ertel 1965, SD: Osgood 1952) – via so-called “impression qualities” (compare Timmermann 1989, 1991; Burrrer 1992, Steinberg 1985, 1987, 1992; Vanger et al. 1985). While these scales register the impression of an improvisation, Mahler (1994) tries to focus on the behaviour of the person who is making music. Similarly, the scales or descriptive systems designed by Möller (2002), Plahl (2000) and Schumacher (1999) all follow theories or principles of developmental psychology in their categorizations. They contain distinct statements on aspects of a child’s development and are therefore particularly appropriate for work with developmentally impaired or delayed, autistic or multi-handicapped children.
In psychiatry, however, and in child and adolescent psychiatry in particular, these scales are of limited usefulness only: patient development in these cases is not delayed but impaired by a psychiatric illness, or impaired or distorted in partial aspects; accordingly, the disturbance becomes evident not so much in impaired development but rather in the way a patient perceives, thinks, feels, and acts, in other words, in his behaviour. It is a specific diagnostic challenge in psychiatry to grasp these aspects and thus to get a clear impression of the type and degree of the disorder. Information received from such patients is often flawed and self-contradictory so that a researcher has to rely on anamnestic data from their environment and on elaborate observation procedures.

In this context music therapy as a nonverbal, creative therapy may provide a significant contribution to a more detailed description of a patient’s experience, perceptive abilities, expressive potential or communicative skills. But unfortunately, no valid, economical and sufficiently objective descriptive methods have been developed for music therapy so far. This is why I decided to design a scale for this purpose as part of my diploma thesis in psychology at the University of Wuerzburg.

1. Design of preliminary MAKS scale

I based the design of the scale on interviews with experts at a workshop for basic music therapy research in Ulm in 1994. In addition, I generated items from existing scales and from minutes of my own therapy sessions and evaluated them in depth in a workgroup called “Musiktherapie in der Kinder- und Jugendpsychiatrie Bayern” (music therapy in psychiatry with children and adolescents in Bavaria).

In choosing the scale type as a system of categories or open sign system, I intended to meet the criteria of one-dimensional behavioral aspects,
equal distances between steps, sufficiently high differentiation and scope, and comprehensive and independent behavioral aspects. This turned out to be difficult in some instances: On the “edge” of the scales, qualitative breaks seemed unavoidable sometimes if “healthy” behaviour was to be demonstrated just like extremely deviant behaviour known from pathologically conspicuous patients or those with extreme behavioral disorders.

The scale was assessed for clarity in a preliminary test with psychology students and music therapists, and reviewed subsequently. The result was the first version of MAKS.

The expression scale comprises the following 14 items and 4 generic terms:

- The way the patient handles the instrument is described via the items choice of instrument, tonal range and initiative. The generic term “shaping/interpretation” comprises the items of formal shaping, structure and variation.
- The items of vigour, tension, flow, vivacity and dynamics belong to the category of “vitality and dynamic expression”.
- The last block, that of “expressive quality” comprises the aspects of tonal quality, expressive quality, emotional expression and subjective experience.

The communication scale has 13 items and resembles the expression scale in structure. The patient’s play is evaluated here in its relation to the music-making of the other person:

- the generic term “general engagement” covers the items choice of instruments (in relation to the partner), autonomy, involvement, length of phrases and use of space.
- In the next category, a patient’s “relation to the other” is explored in more detail with the items of reference, contact behaviour, contact intensity and dominance.
• “Expressive quality” then underlines qualitative aspects: dynamic, affective and playful qualities in joint music-making with the partner and the logical structure of the musical encounter.

Both scales exclusively address the behaviour of only one player, i.e. either the patient or the therapist.

2. Specific questions

In a first evaluation of the scale according to traditional test quality criteria, the following questions were explored:

1. Objectivity: Are the observations of behaviour registered in the scale independent from the person of the observer, i.e. do different observers reach the same or similar conclusions on behaviour?

2. Reliability: Are the results gained from the scale reproducible? Or: To which degree do the results of one measurement point correspond with the results from another?

3. Validity (construct validity): In the absence of a valid external criterion to register nonverbal expressive and communicative behaviour, my focus was on issues of internal validity:

• Potential for differentiation: Does the scale differentiate sufficiently between different behavioural characteristics shown by patients or presentations of disorders?

• Independence of items (homogeneity): Are the individual items on the scale independent from each other, or to which extent do they register similar behavioral aspects?

• Internal structure: Is it possible to summarize individual items under superior behaviour categories?

3. Methodological procedure

In order to validate the scale, as many raters as possible should evaluate video excerpts from therapy sessions with various patients at different times of data collection with this scale.
3.1 RANDOM SAMPLE OF BEHAVIOUR

The adolescents who consented to be recorded on video were between 16 and 17 years, i.e. mostly homogeneous in age, but as heterogeneous as possible in their psychopathological states (two “healthy” adolescents were included). The random sample was intended to cover the widest possible range of behaviour types.

3.2 VIDEO MATERIAL

A music therapy session with adolescents was slightly standardized for evaluation purposes. Two scenes were selected from each recorded session recorded: one scene where the patient tries out an instrument alone (solo play: on the drum, for technical purposes of video recording); and one scene where the therapist played the bass slit drum together with the patient (duet).

The many scenes were cut together to one videotape, with ten solo scenes at the drum and 10 duet scenes at the bass slit drum. Each scene lasted for about 20 sec. and was played twice in sequence. 3 training scenes at the beginning provided a short introduction for raters. As many reviewers and raters as possible were to evaluate the selected video scenes on the basis of the scale.

3.3 RATER RANDOM SAMPLE

52 music therapists had volunteered to act as raters and in a three-hour session assessed the video scenes on the basis of the scale.

There were four different groups of raters, categorized according to their previous experience in order to compare the quality of their evaluation with the experience of the reviewers:

- Students of music therapy in their first year (1/2 year of practical experience on average),
- students in their third year of music therapy training (1.5 years of practical experience on average),
- music therapists with less than four years of professional experience (2.4 years of practice on average), and
musicians with over six years of practical experience (9 years of practice on average).

3.4 RATING
Each rating session started with an introduction and explanation of the scales and the terms involved. Questions were answered. 3 training scenes were played to test the procedure, and questions were discussed. Subsequently, the 10 solo scenes were evaluated with the expression scale. After an interval, the procedure was repeated with the communication scale. In addition, the raters commented on their subjective state (tiredness), they gave individual assessments of difficulty, efforts, the inconvenience caused by the sound quality of the recording, and familiarity with the terms used.

3.5 MEASUREMENT POINTS
34 out of these 52 colleagues were prepared to perform the same assessment once again, so that measurements were made twice, with an interval of 4 to 6 weeks.

4. Results

4.1 OBJECTIVITY
A measure of objectivity was the degree of conformity between observers, interrater reliability, a measure for the relation between individual reviewers.

FIGURE 1. a and b: Interrater correlations per item on the expression scale (left) and communication scale (right) at the first measurement point. In the
The figure shows that the median rater conformities of each item on the expression scale (in figure 1a left) were clearly above the random value (0). Some items reached median conformities ($r = 0.5$); the item vigour showed high correlations.

Nevertheless, several items also had a low interrater conformity: the items formal shaping, structure, flow and emotional expression, and in particular the items logical structure and contact intensity. At the second measurement point, however, many items improved as to interrater conformity.

The communication scale (figure 1b on the right) does not come out quite as well in general, which may also be due to tiredness or declining motivation in the second half of the rating session.

Medium correlations were shown for the items involvement, length of phrases, use of space and dynamic quality; low correlation values were
shown for the items logical structure and contact intensity as well as for the item dominance. These items again improved at the second measurement point, which suggests a training effect.

4.2 RELIABILITY OF ASSESSMENT

The differences between the two measurement points were taken as a measure for reliability in this context: in 40-60% of assessments, there was absolute conformity (i.e. zero differences, indicated here by dark sections of bars). If the +/- differences by individual raters are accepted as “equal assessments” as a somewhat more tolerant measure, then there is a very high degree of conformity of 40 to more than 90% of assessments (lighter sections of bars). The kappa coefficient as the stricter criterion with values between .2 and .4 is not very high, however.
4.3 VALIDITY

In the absence of an external validity criterion, validity was determined via differentiation capacity, homogeneity of items, and factor structure of scales.

4.3.1 Differentiation capacity. A statement on the differentiation capacity answers the question whether the scale is really able to differentiate between different patients or relevant behavioral characteristics, i.e. whether the differences the scale indicates between patients are larger than the inaccuracies in measurement or the differences recorded by various raters on individual scenes. A variance analysis was calculated with the Friedman test that presented highly significant results for each item.

Each item may therefore show highly significant differences between patients. An important criterion for the test quality regarding validity has therefore been met.

4.3.2 Homogeneity/independence of items. The independence of items from each other was evaluated with the consistency analysis (calculated with Kendall’s correlation coefficient tau):

**FIGURE 3.** a and b: Consistency analysis of expression scale (left) and communication scale (right) covering individual scale items. The symbols or dots indicate the degree of the reference of each item to one other item
respectively. For each item on the expression scale there are 13 of such dots or indicators of reference, for each item on the communication scale 11.

The value 0.3 (marked by the black reference line) may be defined as an assessment criterion for evaluation of internal consistency; this means that all items with values below represent less than 10% common variance with the item in question. Those items on the expression scale that describe formal aspects (formal shaping, structure) were observed as relatively independent items with references to less than 1/4 of the other items. Two items on the communication scale (contact intensity and logical expression) registered no references at all.

References to more than 1/4 of the other items were recorded for those items that describe qualitative aspects (affective and vitality aspects) (e.g. flow, vivacity, dynamics, dynamic qualities, affective qualities, playful qualities). One or the other item might therefore be left out in a reviewed scale.
It was interesting to observe negative references to other scales for the item affective quality, i.e. the higher the “affective quality”, the less pronounced are the other aspects of communicative behaviour. Only a few individual values were above the “measure of medium reference” of 0.5, so that we may cautiously assume that the independence of scales postulated in theory is mostly assured. At the second measurement point, these values remained rather stable.

4.3.3 Factor analysis. A factor analysis permits to sum up items under one category and therefore also represents the internal structure of the scale.

TABLE 1. hypothetical scale structure (above) and statistically determined factor structure (below) of expression scale with the factor charges at 1st and 2nd measurement point in brackets.

<table>
<thead>
<tr>
<th>handling of instrument</th>
<th>shaping, interpretation</th>
<th>expressive vitality dynamics</th>
<th>expressive quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>TR=tonal range</td>
<td>FG=formal shaping</td>
<td>SK=vigour</td>
<td>KQ=Souns quality</td>
</tr>
<tr>
<td>IN=initiative</td>
<td>ST=structure</td>
<td>SP=Tension</td>
<td>AU=expressive quality</td>
</tr>
<tr>
<td>VR=variation</td>
<td>SF=flow</td>
<td>EA=emotional expressivity</td>
<td></td>
</tr>
<tr>
<td>LB=vivacity</td>
<td>EL=perception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DY=dynamics</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 2. hypothetical scale structure (above) and statistically determined factor structure (below) of expression scale with the factor charges at 1st and 2nd measurement point in brackets.

<table>
<thead>
<tr>
<th>flexibility</th>
<th>form</th>
<th>vigour</th>
<th>vitality</th>
<th>emotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>TR (.68, .70)</td>
<td>FG (.76, .82)</td>
<td>SK (.91, .88)</td>
<td>SF (.82, .85)</td>
<td>AU (.74, .73)</td>
</tr>
<tr>
<td>IN (.79, .75)</td>
<td>ST (.85, .83)</td>
<td>SP (.83, .85)</td>
<td>LB (.73, .75)</td>
<td>EA (.84, .87)</td>
</tr>
<tr>
<td>VR (.82, .81)</td>
<td></td>
<td>KQ (.82, .82)</td>
<td></td>
<td>EL (.65, .61)</td>
</tr>
<tr>
<td>DY (.61, .49)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Within the expression scale (table 1 and 2), the hypothetical structure was mainly confirmed. The factor vitality/expressive dynamics alone was subdivided, only three items changed the category. In general, the individual factors were occupied almost equally, the factor charge was rather high, and the factor structure was stable at the second measurement point as well. Consequently the overal result was satisfactory for the expression scale.

With regard to contents, the items “tonal range” and “initiative” were grouped together with the items “variation” and “dynamics” to form the category “flexibility”. The items “formal shaping” and “structure” were kept together under the aspect of “form”. “Vigour”, “tension” and “structure” formed another factor “power”. “Flow” and “vivacity” were combined to a “vitality” factor. And finally an “emotion” aspect comprised “expressive quality”, “emotional expressivity” and “experience”.

**TABLE 3. hypothetical scale structure (above) and statistically determined factur structure (below) of the communication scale with the factor charges at the 1st and 2nd measurement point in brackets**

<table>
<thead>
<tr>
<th>general engagement</th>
<th>relation to the partner</th>
<th>expressive quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT = autonomy</td>
<td>BZ = relatedness</td>
<td>DQ = dynamic quality</td>
</tr>
<tr>
<td>BT = involvement</td>
<td>KV = contact behaviour</td>
<td>AQ = affective quality</td>
</tr>
<tr>
<td>DA = length of</td>
<td>KI = contact intensity</td>
<td>SQ = playful quality</td>
</tr>
<tr>
<td>phrases</td>
<td>DO = dominance</td>
<td>LA = illogical structure</td>
</tr>
<tr>
<td>RA = use of space</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For the communication scale (table 3 and 4), the hypothetical factor structure was not substantiated to the same degree. In addition, the unfavourable reference values of the items “contact intensity” and “logical structure” impaired the calculation of the factor structure. An elimination of these factors results in a 2-factor structure (as shown here) that – unfortunately – suggests a different scale distribution at the second measurement point: the item “dynamic quality” charges the factor 1 at the first measurement point, and the factor 2 at the second. The items “involvement”, “relatedness”, “contact behaviour”, “playful quality” and “use of space” might be grouped together to form a “contact” aspect; the first factor might be described through the items autonomy, length of phrases, dominance, and might be titled “independence”.

5. Application of MAKS

After the scale was designed, short studies were performed to substantiate the applicability of MAKS and to confirm the scale as a sensitive tool for measurements:

Plum (1998) evaluated a total of 13 patients at the start, in the middle and at the end of a two-month music therapy in group sessions. Evaluation
tools were a scale to record so-called positive and negative symptoms (PANSS = Positive and Negative Syndrome Scale), a scale to record extrapyramidal symptoms (EPS = extrapyramidal symptom scale) and selected items from MAKS that were assessed by three raters. The results of the EPS did not show any changes that might have influenced the patients’ ability to play. The results from the MAKS evaluation, however, suggested positive developments for particular patients observed individually over the therapy course, with a more differentiated and varied description of the process. These changes also effected the median, although to a smaller degree than for the individual observation. These findings were confirmed in the evaluation of the positive and negative symptoms scale (PANSS) that recorded a slight symptom improvement for patients.

A study by Isermann (2001) also investigated schizophrenic patients (N=5) in music therapy group sessions and also collected data at the start, in the middle and at the end with a variety of measurement tools. In addition to selected items from MAKS he employed the qualitative method designed by Smeijsters (Smeijsters 2000) and a self-assessment questionnaire designed by Reker (1991). The results gained from MAKS were collected by a total of 8 raters from selected video excerpts and in general showed a high conformity in interrater differences (ca. 0.5 scale points despite bilingual data collection). A comprehensive collection of data was possible for two patients only. In both cases, marked changes were observed via MAKS for all values over the course of the therapy, and they were confirmed by the results of the qualitative evaluation according to Smeijsters and also by the nursing staff and the therapist’s personal impression. Partial discrepancies in both the positive and the negative sense were found only in the self-assessment questionnaire according to Reker.
6. Summary and outlook

The MAKS scale was designed for want of objective description criteria in my work with children and adolescents. For these clients in particular, scales for assessment by others constitute the most significant instrument in therapy evaluation. The scale may also be used for adults, and in particular for patients with verbal or reflexive deficits for whom therapy evaluation via self-assessment scales is not appropriate.

In continuation of the project, the objective is to have trained raters compare and externally validate expression and communication profiles of individual patients or patient groups on the basis of this scale. Such a study would definitely validate MAKS. In addition, a music therapy “typing” of patient groups gained in this way might provide a theoretical basis for the music therapy indication. A parallel evaluation of patients’ and therapists’ musical behaviour as a further step might serve to assess significant methodology issues as well.

The evaluation results from MAKS and the findings by Plum and Isermann suggest that MAKS is a promising research tool. With a slight modification of the scale and an intensive rater training prior to application, the scale may describe nonverbal expressive and communicative behaviour in an objective and reliable manner and thus provide the basis for future research.

References:


Osgood C E (1952). The nature and measurement of meaning. Psychological Bulletin, 49, 197ff


Music therapy in the treatment of children with migraine

Project “KiM” –Comparative therapy study on the effectiveness of music therapy treatment of children with migraine headache*

Anne Kathrin Nickel¹, Thomas Hillecke¹, Rieke Oelkers², Franz Resch², Hans Volker Bolay³
¹German Center for Music Therapy Research (Viktor Dulger Institut) DZM e.V.
²Child and Adolescent Psychiatry of the University Heidelberg
³University of Applied Sciences Heidelberg
*Research Project sponsored by SRH-Gruppe, Heidelberg and Weber&Weber, Germany

Abstract:

Migraine in childhood is a serious health problem with a tendency towards chronification. According to the bio-psycho-social model migraine is considered a disorder which is generated by multiple factors and which requires an interdisciplinary treatment concept consisting of
Music therapy in the treatment of children with migraine

Introduction

The music therapy treatment concept presented in this article is currently being applied and evaluated within the framework of an interdisciplinary effectiveness study on prophylactic treatment of pediatric migraine carried out by the German Center for Music Therapy Research, Heidelberg and the Child and Adolescent Psychiatry of the University Heidelberg. Music therapy is being evaluated against drug and placebo treatment. Results of data analysis will be available in summer 2003.

Pediatric Migraine and its Treatment

Headache is one of the most common somatic disorders in schoolchildren. 80 to 90% of children and adolescents between 6 and 16 report having experienced headache, while in the 1960s and 1970s it was only 45%. The prevalence of recurrent or persisting headache – headache forms which need special treatment – has also risen, while the mean manifestation age has fallen considerably since the 1960s. Already 8% of children starting school suffer from these symptoms. This number doubles by the end of the first year, implying that school might likely be one of the important factors that influence the development of headache. At the age of 17, around 17% of adolescents suffer from recurrent headache (Denecke and Kröner-Herwig 2000).

Pediatric headache that requires specific treatment belongs to the group of migraine headache in many cases. Early diagnosis and sufficient treat-
ment is important, not only to facilitate immediate relief, but also because coping patterns, established in adolescence frequently persist throughout adulthood. While around three quarters of adult headache patients are insufficiently treated, in childhood and adolescence this number is even higher. Reasons herefore are the lowering of the mean manifestation age over the last decades, difficulties in diagnosis and the fact that parents tend to seek treatment for their children relatively late.

There are so far only few studies on the prognosis of pediatric headache. Pediatric migraine persists into adulthood in around 60% of cases (Bille 1981), especially in the case of psychiatric comorbidity. The risk of chronification rises with the number of psychiatric disorders. In a large study, headache persisted in 85% of the children and adolescents with multiple psychiatric disorders, whereas only 60% of children without comorbid psychiatric disorders retained their headache throughout adult lives. (Guidetti et al. 1998). Therefore, it is indispensable to diagnose and treat psychiatric comorbidity in children with headache as early as possible.

Children suffering from headache show more behavioral disorders and are especially prone to internalizing disorders (Just et al. 2000). A higher psychiatric comorbidity is well-known in migraine, predominantly with anxiety and depression, but also with suicide attempts and pharmacodependency. It is likely that there is a bi-directional relation between depression and migraine, i.e. each of the two diseases makes the occurrence of the other more likely. More recent studies highlight a definite correlation between migraine and anxiety (Guidetti et al. 1998). According to Denecke and Kröner-Herwig (2000), emotional stress reactions are a key trigger for migraine attacks. Dispositional hypersensitivity combined with stress situations seems to be a suitable paradigm (diathesis-stress-model) to explain pediatric migraine.
Prophylactic drug treatment for children and adolescents is uncommon due to the occurrence of multiple side-effects. Non-pharmacological treatment (relaxation training, biofeedback, psychological therapy) is equal or superior to prophylactic pharmacological treatment of pediatric migraine (Kröner-Herwig and Ehlert 1992). Studies have shown the effectiveness of progressive muscle relaxation according to Jacobson, cognitive-behavioral therapy and thermal biofeedback. Psychological interventions show a bigger effect on children and adolescents than on adults. An early modification of coping patterns for stress and pain may help to prevent a chronification of headache. More recent studies present evidence that psychologically based interventions lead to a long-term reduction of headache after a relatively short treatment period (Denecke and Kröner-Herwig 2000).

The Heidelberg Music Therapy Manual for Pediatric Migraine

The Heidelberg Music Therapy Manual for Pediatric Migraine is an artistic psychotherapeutic intervention based on the bio-psycho-social paradigm (Engel 1977). Theoretical assumptions of the Heidelberg Music Therapy Manual for Adult Pain Patients, the effectiveness of which was proven in a recent study (Hillecke et al. 2002), were taken into consideration and adapted to the requirements of child therapy.

We consider a combination of common factors of psychotherapy and specific music therapy factors to be the basic work mechanisms of our concept. Common factors (like extra-therapeutic change, relationship factors, expectancy) are often discussed in modern psychotherapy research and seem to have more influence on therapeutic success than specific techniques of different therapeutic schools (see Lambert 1992).
We integrate this concept by paying special attention to the development of therapeutic alliance and setting factors.

The specific music therapy factors are partly based on the concept of “emotional inflexibility” and “inhibited expressiveness” by Traue (1998). Traue has shown in studies that adult headache patients’ reaction to anger-inducing situations differs from that of the control group. They show less anger in facial expression and gestures, but report to feel more anger. Many pain patients focus on pain experience and hereby become inhibited in their actions and reactions. In migraine the unpredictability of recurrent pain interferes with the patients’ regular activities and leads to a feeling of lack of control. Social relations but also the image of self and the body image are usually affected. Quantity and quality of well-being-experiences diminish. Life situations are often associated with pain or the anticipation of pain, i.e. the pain patient lives in a so-called pain-state. The musical flexibilization is a specific music therapeutic work factor which has been deduced from this concept of “emotional inflexibility” and “inhibited expressiveness”. It can be achieved through the application of different techniques (e.g. variation of musical parameters in free improvisation). Other specific music therapeutic work factors important for this concept are the communicative effects of music (development of a relationship by shared interactional experiences), emotional and creative activation through music, the symbolic character of music, the distracting and relaxing effects of music (e.g. reduction of tonicity), motor-exercising effect of music (e.g. training of body awareness), music as a facilitator of imagery, music as reinforcement.

The manual is conceptualized for children between the age of 8-12. We considered age-specific pain concepts and coping mechanisms (see Resch 1999) of children from this age-group. These children are, according to Piaget, still mainly in the concrete-operational phase. Only the 11-
12 year old children are on the brink to the formal-operational phase. In the concrete-operational phase thinking is still linked primarily to actual events and explanation for reasons of pain are still deduced primarily from observable situations. But there is also already a certain capability for reversible thinking and integration of psychological factors as headache agents. Therefore our concept focuses on behavior-oriented coping strategies and on the use of imagination and relaxation exercises which are specifically created for this age-group. Individual therapy allows us to take the individual differences in developmental stages into account.

The therapy manual also integrates family therapeutic approaches to pediatric pain therapy (e.g. Turk et al. 1987). Migraine often occurs in so-called “pain families”, i.e. in families where other chronic pain syndromes appear frequently. Therefore it is probable that model learning plays an important role in pathogenesis. Moreover studies have found empirical evidence for operant learning processes in pediatric headache (Turk et al. 1987). Also, chronic illness can have a negative effect on family life (e.g. in the form of over-protectiveness or social retreat). There is a consensus among family-system theorists that certain characteristics in familial interaction have an important impact on occurrence and persistence of psychosomatic syndromes: enmeshment, rigidity and conflict-avoidance (Minuchin et al. 1978). These models have also been conferred to chronic pain syndromes in children.
After thorough physical and psychiatric diagnostics and pain assessment carried out by physicians of the Child and Adolescent Psychiatry of the University Heidelberg, the children and parents visit the Outpatient Clinic of the Music Therapy Department of the University of Applied Sciences Heidelberg for a family interview and music therapy assessment.

The music therapy treatment lasts for 12 weekly sessions in an individual setting. The therapy rooms are especially equipped and laid-out for child therapy, fixtures featuring the usual music therapy instruments – melody instruments (vibraphone, piano, guitar etc.) and percussion instruments (conga, djembe, gong, monochord, bass drum, tambourine etc.).

In addition to music therapy we offer family coaching once a month. The children are also provided with standard medical care every four weeks (general health counseling and acute medication if necessary). All ther-
apy sessions are monitored and video-taped. Interdisciplinary supervision meetings take place every week and once a month interdisciplinary case presentations are held.

**FAMILY INTERVIEW**

The family interview focuses on the following aspects: the treatment context is presented and explained, individual therapy goals of the parents/child are asked for, general therapy goals of music therapy treatment are explained, pain biography, pain concept and function of pain in the family are explored.

**MUSIC THERAPY ASSESSMENT**

The following parameter are being assessed in the first contact with the child: musical socialization and preference, musical response, variability in musical expressiveness.

**FAMILY COACHING**

The family coaching focuses on the following aspects: appreciation of present coping strategies, identification of possible learning factors for pain in the family (positive and negative reinforcement of pain behavior by parents, model learning), the families’ way to dealing with emotions, conflicts and achievement, intimacy-distance-regulation within the family. Additionally this coaching aims at a continuous evaluation of therapy goals as well as a transfer of therapy achievements into the every-day family life.

**MUSIC THERAPEUTIC TREATMENT GOALS AND TECHNIQUES**

For the music therapy treatment a manual was conceptualized according to the theoretical foundation described above and on the basis of clinical experience.

For the conceptualization of the manual the phase model for psychotherapy outcome, which has been empirically well founded by Lueger (1995), has been taken into consideration. According to this model there is a chronological order in psychological change. In the first phase of
therapy the patient improves mainly on the dimension “subjective well-being” (remoralization), then on “symptoms” (remediation) and towards the end of therapy on “general functioning” (rehabilitation). In our manual these dimensions (remoralization, remediation, rehabilitation) are focused successively and worked on with specific therapeutic techniques.

Each therapy session is framed by rituals, i.e. in the first session “hello”- and “good-bye”-songs or rituals are created with the child and then repeated every session. The imagery and relaxation exercises established in the first session are also repeated every session. Prophylactic interventions such as learning how to deal with stress- and conflict situations, but also relaxation training for use in acute situations (at first signs of a beginning migraine attack) are part of this manual.

<table>
<thead>
<tr>
<th>Goals according to the phase model by Lueger (1995)</th>
<th>Therapeutic goals</th>
<th>Specific factors of music therapy</th>
<th>Music therapy techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I: Improvement of subjective well-being (4 sessions)</td>
<td>Building of a relationship</td>
<td>Relationship building by the unifying experience of musical interaction</td>
<td>Duo plays</td>
</tr>
<tr>
<td></td>
<td>Activation of “remembered well-being”</td>
<td>Musically supported activation of cognitive and emotional resources</td>
<td>Musically guided imagery with induction of relaxation</td>
</tr>
<tr>
<td></td>
<td>Training of body awareness</td>
<td>Music as a tool for increasing physical perception and expression</td>
<td>Body percussion Guided movement with music Vibro-tactile stimulation</td>
</tr>
</tbody>
</table>
To illustrate special techniques of the manual we present a practical example of our work with Daniel (9 years) in the following.

First impression:

At first sight Daniel presents an inhibited and prudent impression. At the same time he behaves compliantly and in a socially accepted way. In the music therapy room he becomes more relaxed and shows age-adequate behavior (rocking on the chair, wandering in the room). The boy shows no psychomotoric or mental challenges.

Family interview
Daniel reports fighting a lot with his brother (+3 years), the mother usually intervenes in order to make the boys come to terms. Daniel would like the whole family to engage in leisure time activities more frequently.

Music therapy assessment

Musical behavior: no flexible reaction to variation of rhythm, tempo and dynamics; when duo playing at the bass drum the boy shows a somewhat strained grimacing and lifting of shoulders.

Music therapy treatment

Phase 1: The therapist introduces a ritualized “hello”- and “good-bye”-song (“Hello, Daniel, how nice that you are here” / “The session is over, Daniel goes home for today…”). After Daniel is initially hesitant in participation, this structure seems to provide him with the security he needs for relationship building and gradual approximation to the instruments / his own voice. In each session the child is offered musically guided imagery and relaxation. For this, Daniel lies down on two beanbags and the therapist plays calming and open chords on his favorite instrument - the vibraphone. Daniel experiences his personal “well-being daydream”, in which he imagines undertaking a journey through the jungle on the back of a big elephant, his friend and guardian. Initially it is difficult for him to relax for more than 30 seconds, but with each session he is able to let go a little better. In this phase of therapy, musical contact plays or duo plays are of special importance. These are improvisations in which the therapist and the child share one instrument (gong, bass drum, log drum) sometimes using voices as accompaniment. Daniel hereby learns to breathe more deeply and his posture improves considerably.

Phase 2: During the imagery and relaxation exercises Daniel is now able to relax so deeply, that his body jerks spasmodically. He seems more
cheerful and to have gained confidence. This shows in activities like his counting in the “hello”-song. In this phase, symptom improvisation is used to symbolically externalize Daniel’s headache. Daniel chooses the bass drum as the acoustic representation of his symptom. The headache is played by the therapist, while Daniel plays the piano, fighting the headache. Daniel “wins” and seems to profit from the possibility of converting the painful physical symptom into sound, thus relating to it and making it tangible. He learns that he does not have to passively endure the pain but can actively influence it. In a ritual improvisation “freedom from pain” is musically enacted. For this “happiness music”, Daniel chooses the guitar and asks the therapist to play the piano. During the improvisation he starts to whistle, which he often does when feeling good. Daniel becomes more flexible in his body language and in his reaction to the variation of musical parameters. For the upcoming school holidays he takes a small drum home to help him in case he has another migraine attack.

Phase 3: In a reality improvisation Daniel practices saying “no” and handling arguments. His musical expression is loud and definite. In musical contact Daniel always wants to have the last word. In musical role plays Daniel learns to deal more adequately with fights, conflict situations and aggression. Daniel reports finding it easier to stand up to his older brother now. In reality improvisations, self-confidence boosting experiences are induced. Daniel is encouraged to explore and name things he likes about himself. At the end of Daniel’s treatment, the results of therapy are reflected on and reenacted in a musical self-portrait, in which Daniel can again arrange his strong and not so strong points musically. Daniel has been able to greatly enhance his self- and body-awareness and has gained a good level of sensitivity towards his personal needs. While therapy was ongoing, the frequency of Daniel’s migraine attacks decreased consider-
ably, and in a follow-up interview 6 months after end of therapy his mother reports that Daniel no longer suffers from migraine.

**Literature**


Correspondence

Anne Kathrin Nickel
Deutsches Zentrum für Musiktherapieforschung (Viktor Dulger Institut)
DZM e.V.
Maaßstr. 28
69123 Heidelberg
Strategies for searching electronic databases

Simon Gilbertson and David Aldridge

Abstract

In this paper we share some of our experiences made in searching the literature during the first stages of a Systematic Review Project.

A literature search is a fundamental process for every research project whether it is a systematic review or a traditional literature review. By searching for previously published literature on the topics that we are investigating, then we locate our study in the broader of context of other studies.

The main body of this paper focuses upon searching electronic databases for references in the databases MEDLINE and MTDATA4.

We give a suggestion for an optimal search-description strategy and conclude with a quick reference checklist for use in designing and planning future literature searches.
Strategies for searching electronic databases

We begin our research endeavours with an idea about what we want to study. And this idea is often related to a broader field of study. In the project described here, we are making a systematic review of music therapy studies published over the past twenty years with the aims of eliciting a substantial body of evidence to support music therapy practice, to discern where evidence is missing and propose future research initiatives that will support music therapy practice. Hopefully, we will also be able to influence policy making regarding service payments for music therapy.

A first stage in this project is to identify the necessary literature that is available. Like any research study, we have to develop a focus for own research study so that we have a general idea about which topics are involved. The next step is to find out what has been written about those topics and how they have been researched in the past. This places our study within a broader ecology of ideas and contextualises what we are doing within the broader context of the international literature related to music therapy practice. All academic researchers need to do this at some stage. A systematic review is a comprehensive form of traditional review.
In his guide to searching the literature, Hart (Hart 2001) describes how ‘a search of the literature:

1. will help you identify work already done or in progress that is relevant to your work;
2. will prevent you from duplicating what has already been done;
3. will help you avoid some of the pitfalls and errors of previous research;
4. will help you design the methodology for your project by identifying the key issues and data collection techniques best suited to your topic;
5. will enable you to find gaps in existing research, thereby giving you a unique topic’. (p. 3)

A literature search is a process that develops and changes during the research project. Initially, a search strategy aims at finding a large amount of literature. Search terms should be broad and comprehensive. During the process it is necessary to reduce the scope of the search and to aim at a higher level of precision in the relevance of the search results to the project. A well-balanced literature review is based on a balanced compromise between comprehensiveness and precision in the process of searching for literature (Clarke and Oxman 2002).
Types of Literature. The literature is made up of a range of types of texts like books, journals, reports, conference proceedings and reviews. A search strategy for finding books demands the use of different resources than a search for dissertations. Later in this paper we discuss the main considerations involved when searching for articles published in journals. The reason why so much emphasis is placed on journal article is that they are often peer-reviewed and reflect the current state of knowledge mediated by expert peer understandings. With the advent of electronic publishing, we have converted some elements of what once was called grey literature to another form, that we may now call pre-published (when that material will appear in a printed journal) or as an online publication. Similarly, CDROMS are also becoming a documentary source for music therapy literature and information.

<table>
<thead>
<tr>
<th>TABLE 1. Types of literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Books and book sections</td>
</tr>
<tr>
<td>Books or monographs make up a large part of the literature. Some books about music therapy are made up of book sections or chapters written by a collection of authors and can portray various facets or perspectives upon a central theme or subject.</td>
</tr>
<tr>
<td>Articles published in journals</td>
</tr>
<tr>
<td>Theses and dissertations</td>
</tr>
<tr>
<td>Theses and dissertations often represent research that is based on in-depth reviews of up-to-date publications. Dissertations are valuable because of their depth of knowledge and specificity. At a doctoral level they will be comprehensive sources of expert information.</td>
</tr>
</tbody>
</table>
Primary and secondary sources

The term primary source is used here to relate to the actual written material. In the last few years, full versions of texts have begun to be offered from some organisations on the Internet. The British Medical Journal offers an electronic version of the complete journal and archive of articles since 1994 at their Internet site (http://www.bmj.com).

The Nordic Journal of Music Therapy also provides full texts of the journal’s articles on the Internet (http://www.hisf.no/njmt/).

Some journals are exclusively published on the Internet. ‘Music Therapy Today’ appears exclusively as an online journal (http://www.musictherapyworld.net).
The production of most of the published primary sources is monitored and recorded. These records of primary sources are referred to as secondary sources.

Secondary sources include bibliographies, indexes and other lists of information (Baker 1999). A secondary source provides a reference to the original material. These references are unique and allow the identification of original material unambiguously. A concise reference provides information about the authors' name(s), and where the material has been published. The following example shows a reference to an (imaginary) article published in a journal:

Schmidt, F. (1995) The importance of the number of hours of sunshine per day in the personal evaluation of a successful holiday. Leisure and Recreation, 4, 2, 124-129

The reference includes the surnames and initials of the authors, the year in which the article was published followed by the title and subtitle of the article, the journal name, the volume and issue numbers and the page numbers.

A reference to a book looks a little different because of the information that it provides:


This reference includes the authors name, the year published, the book’s title, the place published and the name of the publisher.

**SECONDARY SOURCES**

Because so much literature exists, it is impossible to create an overview of the required literature for a research project by solely looking at primary sources. So we turn to organisations that create secondary sources.
There are organisations that produce large electronic databases of references that can be searched using a computer. These databases are provided in two distinct formats; local resources and remote resources.

Local secondary resources are databases that are stored on compact disks and can be searched on your own computer, or a computer in your library or institute. The Information CD ROM’s produced by the University Witten Herdecke are such a local resource. The intention behind their production was that any researcher could have time to browse through a database of references in their own time even if not connected to an electronic network via the Internet, and particularly for those not affiliated to an academic institution. We wanted research material to be available to any practitioner interested in finding out more to inform practice (Aldridge 1993; Fachner 1999).

This CD ROM collection of databases has references to journal articles, books, dissertations and other forms of literature. In addition to the databases, software is provided on each compact disk with which the databases can be searched (EndNote Reader).

Other databases, remote secondary sources, are stored on a ‘central’ computer or server remote to the user and it is necessary to link to this computer via a telecommunications connection. If you have access to the Internet it is possible to search the remote database either with software running on your own computer or at an Internet site that uses the databases’ integral software.

Using commercial databases should be very carefully examined. Online (remote) searching of commercial databases can involve costs of up to €4 for each retrieved reference plus the online charges. It costs simply to see
that the reference exists. There may be an additional charge for looking at the abstract. Retrieval of the articles involves additional costs. If the user prefers to search the database without Internet access, some of the commercial database providers sell copies of the databases delivered on compact disk or obtainable by weekly online download.

We provide an online remote database, free of charge, that can be accessed at (http://www.musictherapyworld.net) under the button Database Research. This database is linked to the CD ROMs and includes a variety of references that are pertinent to music therapy.

When selecting a database, then the content of that database will be important for selecting it. The following selection of databases may include references that are relevant to music therapy.

**TABLE 2. Alphabetical List of Databases**

<table>
<thead>
<tr>
<th>Database</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAIRSS</td>
<td>Music and music therapy</td>
</tr>
<tr>
<td>Cancerlit</td>
<td>Oncology</td>
</tr>
<tr>
<td>Cochrane Library</td>
<td>Medical and therapeutic areas</td>
</tr>
<tr>
<td>Embase 74/ Embase 84</td>
<td>Medical and therapeutic areas</td>
</tr>
<tr>
<td>Gerolit</td>
<td>Gerontology</td>
</tr>
<tr>
<td>LILACS</td>
<td>Medical and therapeutic areas</td>
</tr>
<tr>
<td>MTDATA4</td>
<td>Music and music therapy</td>
</tr>
<tr>
<td>Music Therapy World Online-</td>
<td>Music therapy and related literature</td>
</tr>
<tr>
<td>database</td>
<td></td>
</tr>
<tr>
<td>Music Therapy Database Temple</td>
<td>Music therapy</td>
</tr>
<tr>
<td>Uni</td>
<td></td>
</tr>
<tr>
<td>Psyndex</td>
<td>Psychology</td>
</tr>
<tr>
<td>PsychInfo</td>
<td>Psychology</td>
</tr>
<tr>
<td>Web of Science</td>
<td>Medical and therapeutic areas</td>
</tr>
</tbody>
</table>
Developing a search strategy

There are some general points to consider before beginning a search of the databases. We will refer to this preparation as a search strategy. You will have in your mind the focus of your research. It is a good idea to think about whether there are parts of the literature you do not want to search for. By applying restrictions to your search strategy you can save a large amount of time. Date of publication and publication language are two main factors to be considered.

**PUBLICATION DATE**

Before searching it is important to decide whether you wish to search for literature from a specific era, for example between 1950 and 1975, or whether you are interested in the literature which has been only written in the past five years. It is simple to restrict your search in this manner when using electronic sources. Sometimes you may only be required to click one button and to enter the publication dates you wish to exclude. Of course, you will want to include the latest literature. As so much is currently being written and published in music therapy, then a search over the past five years will generate a substantial amount of literature. If we extend that search to the past ten years, then we have the benefit of a broader perspective, but a lot more to read and analyse. With the advent of electronic media, we have the possibility of finding out how much has been published in terms of references. What we do not have immediately is the actual material to hand. When we do eventually have the material in front of us, then we need another strategy for making sense of it (that is the topic for another paper).

**LANGUAGE**

Before beginning a literature search you should decide whether you want to collect material in any language or only those written in languages you
understand. If you chose to search for texts only written in English, you may miss texts that are highly relevant to your research. For some research projects it may be unacceptable if core texts are omitted on the grounds of the language without any consideration regarding their content. This is referred to as language bias (Egger and Smith 1998). If in doubt, the material should be read by someone who can understand the original language in order to assess whether the text should be translated.

**Searching electronic databases**

This section discusses the major issues that are relevant in searching two electronic databases, MEDLINE and MT DATA 4. As I mentioned earlier, MEDLINE is an online source that is stored in a remote computer that can be access via Internet. MT DATA 4 is a database covering music therapy literature and is stored on the compact disc Information CD ROM 4. As database software (EndNote Reader) is also provided on the compact disk, it is possible to access this database without requiring an Internet connection.

MEDLINE is a database of bibliographical references to journal articles provided by the US National Library of Medicine ([http://www.nlm.nih.gov](http://www.nlm.nih.gov)) and contains indexes of articles from approximately 4,500 journals published since 1966. The journals cover ‘the fields of medicine, nursing, dentistry, veterinary medicine, the health care system, the preclinical sciences, and some other areas of the life sciences’ (MEDLARS 2001).
The database can be searched with various software programmes that have been developed by commercial database providers and the use of these services requires a fixed-fee.

**A free service.** The National Center for Biotechnology Information has developed an additional service called PubMed, listing 4,500 journals, that provides free access to MEDLINE.

When using PubMed it is important to be aware that it is possible to enter your search request in two different places. The most commonly used search page is seen on the opening screen when linking up to PubMed (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi):
FIGURE 2. Initial screen seen when linked to PubMed via Internet

Terms can be entered directly into the search field and clicking the ‘GO’ button starts the search. It is possible to add additional information into
this search field (Search field descriptors), and we will refer to these later in the article.

Once you have carried out an initial search it is possible to view the exact search strategy by clicking on the ‘DETAILS’ button.
FIGURE 3. Search details window

In the central window titled ‘PubMed Query’ you will see the exact search description. It is possible to alter the search by editing the text in
this window. Additional information is given on this page about how PubMed has understood your search query, the number of results found and the name of the database(s) searched.

It is always advisable to use both the opening search screen and the ‘DETAILS’ search screen to monitor your actions. The search must be started with the opening screen. It is possible to refine your search in both windows. The following sections will initially describe the major search functions offered in PubMed and then go on to describe how the search strategy can be refined using further search commands (Search fields descriptions).

The MeSH system is a hierarchical headings system used to categorise references. The use of this categorisation assists the indexing and retrieval process. Furthermore the MeSH terms aim at assisting the user to find references to literature that uses synonyms or alternative terminology. However, various providers of access to MEDLINE map non-MeSH terms to the MeSH terms differently. Thus the MeSH searches carried out with one provider will produce significantly different results than another (Gault 2002). The examples that we will be using here have been made using the PubMed access to MEDLINE.

The term ‘music therapy’ can be found in three different MeSH categories. The sub-headings of the three categories are: ‘sensory art therapies’, ‘rehabilitation’, and ‘psychotherapies’.

**All MeSH Categories**

**Category 1**

Analytical, Diagnostic and Therapeutic Techniques Category

Therapeutics
Complementary Therapies
  Sensory Art Therapies
  Music Therapy

Category 2
  All MeSH Categories
    Analytical, Diagnostic and Therapeutic Techniques Category
    Therapeutics
    Rehabilitation
    Music Therapy

Category 3
  All MeSH Categories
    Psychiatry and Psychological Category
    Behavioral Disciplines and Activities
    Psychotherapies
    Music Therapy
If PubMed recognises your search term as a MeSH term it will retrieve articles which have been indexed with this term. We should not forget - computers only do what they are instructed. Therefore any references that are not indexed with the MeSH term you used to search will not be reported.

AN EXAMPLE FROM PRACTICE USING MESH TERMS

Amongst other topics in Simon’s research, he is interested in finding literature about music therapy and coma. As we have already seen, ‘music therapy’ is a MeSH term. After consulting the MeSH Browser, the term ‘coma’ is also seen to be a MeSH term.
TABLE 3. Results of searching PubMed for music therapy, coma and both terms using only MeSH terms

<table>
<thead>
<tr>
<th>Search</th>
<th>Articles found</th>
</tr>
</thead>
<tbody>
<tr>
<td>#3 #1 and #2</td>
<td>8</td>
</tr>
<tr>
<td>#2 “coma” [MeSH])</td>
<td>12,123</td>
</tr>
<tr>
<td>#1“music” [MeSH])</td>
<td>941</td>
</tr>
</tbody>
</table>

Search date: 16.10.2002

In Table 3, we see the result of searching for music therapy (search 1) and coma (search 2) and how many articles fulfil both criteria when using only MeSH terms (search 3).

The second search mode that PubMed uses is ‘Text word’ searching. This form of searching is based on searching for the exact word you enter in the search request.

It is possible to define which data fields of the entries should be searched. It is, for example, possible to search for the term music therapy only in the title or abstract. By doing this you can avoid receiving references to all of the articles published in a journal that include ‘music therapy’ in the journal name (e.g. Journal of Music Therapy).

The effect of using a text word search strategy, in comparison to using the MeSH terms, is that the results can be much wider but can produce irrelevant results.

Depending on the area of inquiry and the search used, you may receive better results when you use a MeSH term and text word search.
In our example, see Table 4, two additional references were retrieved. These references were:


The first of these references is relevant to Simon’s topic of interest. Through carrying out this ‘Text word’ search important literature has been identified and the literature search results are more comprehensive. Inadequate review of the literature has been suggested by Jones and colleagues (Jones, Scouller, Grainer et al. 1994) as being a possible reason for ‘the scandal of poor medical research’(Altman 1994). In the field of music therapy, where the mass of literature is smaller than that in the medicine, we must take care in not omitting any relevant literature and so ensure a high quality in literature searches.

**BOOLEAN OPERATORS** A further function which PubMed and many other electronic search programmes offers is the ability to combine terms through the use of the
words AND, OR and NOT. These are the so-called ‘Boolean’ operators and can be used to join terms in order to more closely specify the targeted area of literature.

We have seen the effects of combining two search terms with the previous MeSH searches for ‘music therapy’ and ‘coma’ in Table 3. Boolean operators can be used directly in the search term field when entering a search request. The term ‘AND’ requires that a reference contains both terms entered. The term ‘OR’ reports all references where either of the search terms is present. The term ‘NOT’ excludes all references in which the second term is present in references that include the first term. This function can assist in honing in on literature systematically. Imagine you are interested in literature about music therapy with adults and coma. This can be done by removing references from the previous search results which includes the term child through using the Boolean term NOT: music therapy AND coma NOT child. Care should be taken here – in this example you would not receive literature about music therapy and coma and adults, but music therapy and coma but not children.

‘EXTREME SEARCHING’ For some forms of literature search, such as those required of systematic reviews, it is important to carry out an extensive literature search. In systematically searching for literature it is advisable to combine a MeSH search and a text words search and a Boolean search. This model is required for any extensive search that is using more than one single word. As an example, the search request required when using the term ‘music

<table>
<thead>
<tr>
<th>Search</th>
<th>Articles found</th>
<th>Difference to previous search</th>
</tr>
</thead>
</table>

Search date: 16.10.2002

This strategy returned 279 additional references in comparison to the previous two search methods used. It could be that references to articles about ‘physical therapy in water and the use of background music’ are included in these results. These might seem initially not to have much to do with music therapy – but this is only a matter of perspective. The purpose of the literature search is to uncover how others have made use of your search terms in the literature.

Facts affecting search outcomes in PubMed; The elusive missing data. The National Library of Medicine makes changes to the MeSH terms used to index the articles during November and December each year is updated every Saturday and Thursday. Results of searches carried out during these months and days can be erratic. Therefore it may be necessary to repeat searches at other times or to avoid carrying out important literature searches during these months. Not all articles in journals are referenced in the MEDLINE. Journals are selectively indexed and there are indexing policies which might mean that not every item from every journal will be in the database’ (MEDLARS 2001).
For example, the only music therapy journal that MEDLINE indexes is the Journal of Music Therapy published by the National Association for Music Therapy, Inc. MEDLINE is not a reliable source for retrieving references to contents of this Journal however as it does not index all articles in the Journal. The journal is only indexed in MEDLINE post-1976, yet the journal published 231 articles between 1964 and 1977.


Although MEDLINE is often quoted as an exemplary database when looking for references, there is a growing body of knowledge that urges caution. Only 134 references (search date: 15.11.02) were retrieved by MEDLINE using ‘Journal of Music Therapy’ as search term in all fields, including the journal title field. Between 1977 and 1998 the Journal of Music Therapy actually published 357 articles. Obviously, it is necessary to search elsewhere for a comprehensive list of articles published in this journal.

Other reports that show that MEDLINE does not cover a large part of the literature. Dickersin and colleagues searched MEDLINE for randomised controlled trials in the area of ophthalmology and found only 77% of known trials in MEDLINE (Dickersin, Scherer, and Lefebvre 1994). The Cochrane Collaboration (Clarke and Oxman 2001) report that ‘only 30-80% of all known published randomised controlled trials are identifiable using MEDLINE (depending on the area or specific question)” (p. 28). Other investigations have shown that it is not possible to retrieve all ref-
eres contained in the database. Greenhalgh (Greenhalgh 2001) points out that ‘according to one estimate, 40% of material which should be listed by MEDLINE can, in reality, only be accessed by looking through all the journals again, by hand.’ (p.34).

In the age of electronic searching, it is still necessary to do some things the old-fashioned way to be sure; that is, you have to go to the library and look for what you are seeking in the journals. If a database does not reference the complete journal contents then it will be necessary for the researcher to hand search the printed copy of all issues of the journal.

**MusicTherapyWorld online database**

The online database that we have constructed is a cheap and cheerful alternative. It is possible to search using a natural language algorithm http://musictherapyworld.net. Apart from that we provide a local resource database on CD ROM.

**OFFLINE DATABASE:**

‘MTDATA4’ STORED ON INFORMATION CD ROM 4: UNIVERSITY WITTEN HERDECKE

The MTDATA4 database is available on the Information CD Rom 4. All of the databases have been created with the bibliography software EndNote and this program can be used to access them.

MTDATA4 contains references to music therapy literature and has not followed any strict inclusion criteria based on journal selection. The database encompasses 20,604 references to books, book sections, articles, conference proceedings, multimedia sources, editorials and letters. Some of the music therapy grey literature is also indexed in this database. There are references to music therapy literature not covered by PubMed.
PubMed only indexes journal articles but MTDATA4 includes a wide range of publication media.

The EndNote software is a bibliographic manager that can be used to store a large number of references to various forms of published and non-published material. Figure 5 shows the main library window of a database in EndNote.

**FIGURE 5.** The library window of MTDATA4 opened in EndNote.

![EndNote library window](image)

By double-clicking a reference it is possible to view the fields included in that reference (see Figure 6).

### FIGURE 6. Reference window in EndNote

![Reference window](endnote_reference_window.png)

**Author**
Marangos, N.

**Year**
1990

**Title**
Hearing loss in multiple sclerosis: Localization of the auditory pathway lesion according to electrotympanicographic findings

**Journal**
J. Laryngol. Otol.

**Place Published**
Invicta Press, Ashford, Kent, England TN24 8HJ

**Publisher**
Hodder & Stoughton Ltd

**Volume**
110

**Issue**
3

**Pages**
252-257

**Note**

**Short Title**

**Alternate Journal**
Journal of Laryngology and Otology

**ISSN**
0022-2151

**Original Publication**

**Reprint Edition**

**Revision Item**

**Language**

**ISSN Series Number**

**Call Number**

**Label**

**Keywords**
multiple sclerosis; hearing loss; sensorineural; audiometry; evoked response

**Abstract**

Multiple sclerosis is known to affect the myelin of the auditory pathway resulting in acute hearing loss. Two cases of sudden deafness due to multiple sclerosis have been evaluated by conventional audiometry, brainstem auditory evoked response audiometry and tympanometry, electrocochleography. The abnormalities of the compound action potential in

Strategies for searching electronic databases 25
We have been recommending EndNote as a primary research tool to store and make bibliographies over the last decade (Aldridge 1993). This type of programme makes the management of bibliographic references simpler, is accurate when a literature list is produced for publication and a great amount of time can be saved in comparison to managing references by hand.

The search functions offered by EndNote are similar to those offered by PubMed. Similar to PubMed, it is possible to define which field(s) you want to search. The data fields that are offered can be seen in the Figure 7.
FIGURE 7. Search field selection options in EndNote

EndNote also offers the possibility to restrict the search scope through the use of logical operators Figure 8.
FIGURE 8. Logical operators in EndNote’s search window.

As with the PubMed search discussed earlier, it is possible to use Boolean operators. In EndNote this is achieved by highlighting the ‘bullets’ (the on/off buttons) next to the terms AND, OR or NOT in the search window.

A basic initial search for literature about music therapy in the MTDATA4 database using the EndNote programme could look like Figure 9.
FIGURE 9. Basic search for references about music therapy

The results are initially impressive but there are some considerations to be made. The most important consideration is that through the choice of searching ‘All fields’ many references have been included which may be irrelevant. Many fields can include the term ‘music therapy’ without relating to a text that includes the term ‘music therapy’. These fields include; the journal name (you will retrieve all articles written in a journal which has ‘music therapy’ in its name), the authors’ address (The International Music Therapy Centre, Le Havre), and the URL or Internet address (www.musictherapyworld.net).

Therefore, a better search strategy should look like Figure 10.
In specifying the fields to be searched (title, keywords and abstract) it is possible to exclude possibly irrelevant references from the search results.

*Next steps; better indices*

Search results do not always portray an accurate picture of what exists in a database, but reflect the precision of the search procedure. Wigram, Pedersen and Bonde (Wigram, Nygaard Pedersen, and Bonde 2002) published results of searching various databases for music therapy literature. Unfortunately, they provide no information about which databases using
Endnote have been searched, nor about the exact search strategy (term(s), status, search field(s), and relationship). This lack of information makes it difficult to judge the significance of these results.

It is easy to become blinded by large numbers when searching for literature. The quality of a database should not be assessed by the number of references returned alone. It is important to look at the content and completeness of coverage of the databases. The economical issues of searching commercial databases and the amount of time required to search databases should be also considered. The music therapy profession needs research tools which save time and money and which assist in raising the quality of our research activities.

We discovered that the Journal of Music Therapy in MEDLINE is not indexed completely. Most of the major music therapy journals are not indexed in publicly available databases and this makes searching for literature more difficult than it should be. The only options to searching electronic databases are either to visit the Internet home page of a Journal or wade through printed copies of the journals’ tables of contents. Both of these activities take an enormous amount of time.

Because MTDATA4 database has not indexed all issues of the music therapy journals, we have begun to create and complete databases that include references to every article published. At the present time we are creating indices of the journals in collaboration with the journal editors (see Table 6). These indices will be accessible on the next edition of the Info CD Rom and through the Online Database at www.musictherapy-world.net.

- British Journal of Music Therapy (including the Journal of British Music Therapy)
IMPLICATIONS FOR SEARCH AND RETRIEVAL

The peculiarities of MEDLINE and PubMed can severely influence search results. It is of utmost importance to be informed of these characteristics to compile a search strategy and to understand why the results of a search appear as they do.

Selective journal coverage and missing data mean that it is necessary to search multiple databases to become informed about existing literature. Multiple database searching should not be thought of as a speciality of systematic reviews or meta-analyses. The aim of a literature review in a research project is to find the gaps in the existing literature and to build a unique research question upon this knowledge. This aim can only be accomplished through completing a search process using multiple search terms and multiple databases.

Even the best search strategies will not find bibliographic information about primary sources if this information is not included in a database. Therefore, a hand search of significant journals, regardless of whether the journal is indexed or not, is imperative in systematically searching for literature. In the near future it will be possible to rely on selected databases that guarantee complete coverage the articles published in selected music therapy journals.
A standardised search-description is needed to make the used search transparent and to validate reported results. We can then document the results of our findings by showing which criteria we have included in our search procedures. Omitting valuable and relevant literature due to oversimplified search processes will become a thing of the past. A standardised search-description can also help as a reminder when considering the major points of the search strategy.

We suggest that the following information should be included in a standardised search description:

1. Which database was searched (including name of provider)
2. Exact description of the search term
3. The date of the search
4. Status of the search term (MeSH or non-MeSH term)
5. A description of how multiple words were combined (Boolean operators)
6. A description of the database fields searched
7. A description of the software (name and version) and the computer system used (PC/Mac)

A good literature search will cover various databases. Figure 11 shows a search strategy that includes many search procedures. Each search procedure should be documented by a standardised search-description. It is particularly important to be able to reconstruct the search procedures when the results of multiple searches are pooled into a single bibliographic database. It is a good idea to label the references with a code relating to the search procedure used to be able to retrace the original sources of each reference.
This paper has aimed at highlighting the complexity of carrying out a literature search. To conclude, in Table 7 we offer a short reference guide that can be used whilst planning a literature search.
### TABLE 7. A quick reference guide to searching electronic databases for literature references

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Think about what you actually want to find. Rephrase your area of inquiry as a question, analyse the terms you have used and make a list of alternative search terms. Never rely on a single search term.</td>
</tr>
<tr>
<td>2.</td>
<td>Think about where you are going to search. Decide which database (and provider) you will search based on its contents and coverage.</td>
</tr>
<tr>
<td>3.</td>
<td>Think about when you will carry out the search. Check the database is not being updated or that maintenance work is being carried out.</td>
</tr>
<tr>
<td>4.</td>
<td>Check the costs…before you start searching! This includes the cost of finding references and the cost of retrieving full-texts online or by post.</td>
</tr>
<tr>
<td>5.</td>
<td>Get informed about how the database functions before searching. Many databases provide tutorial facilities.</td>
</tr>
<tr>
<td>6.</td>
<td>Begin with a MeSH search. Remember the function of search field tags.</td>
</tr>
<tr>
<td>7.</td>
<td>Add a Text Word search. Be aware that the results may be wider but irrelevant.</td>
</tr>
<tr>
<td>8.</td>
<td>Combine search results (MeSH and Text word) using Boolean operators. Increased accuracy.</td>
</tr>
<tr>
<td>9.</td>
<td>Carefully analyse the references you have retrieved, Adapt your list of search terms and repeat steps 1, 2, 3, 6, 7, 8.</td>
</tr>
<tr>
<td>10.</td>
<td>When retrieving the references be sure to check that they are complete. This will save valuable time when you want to retrieve the original material. It frustrating to find that the journal pages are missing, or you know which year but no in which issue to look. If possible, also check that the ISSN numbers are documented.</td>
</tr>
<tr>
<td>11.</td>
<td>Be prepared to search by hand.</td>
</tr>
<tr>
<td>12.</td>
<td>Document your search carefully. Use a standardised search-description to validate your results.</td>
</tr>
</tbody>
</table>
References


Author’s address

Research Assistant

Prof. D. Aldridge, B.Ed., B.Phil., PhD.
Chair for Qualitative Research in Medicine

Communication to
Institute for Music Therapy
University Witten Herdecke
Alfred-Herrhausen-Str. 50
D-58448 Germany
Telephone 0049 2302 926 780 fax 0049 2302 926 783
Music Therapy in Psycho-oncology – A Gender Comparison Research Project

Gaertner, B.; Seidel, A.

A research project of the Master’s Course “Music Therapy” at the University of Applied Sciences in Frankfurt/Main

Oncology and palliative medicine are fields of practice of growing importance in which new tasks have emerged for musical therapy within the last years. It is not surprising that there is a steady growth of practical and research interests with regard to music therapy in oncology. The definition of music therapy as part of psycho-oncology and its integration in
medical treatment is an impressive manifestation of a change of paradigm in medicine which could be roughly described as a transition of an emphasis on deficits (being sick) to an emphasis on resources (becoming healthy). This change of paradigm entails a great challenge in view of a serious illness, an illness which has an uncertain prognosis and which involves a total disruption of life. The aim consists in qualitatively defining and securing the patients’ survival and their management of life – despite limited possibilities and a diminution of hope. Music therapy seems to be well suited as a form of treatment in this context.

One aspect has been totally neglected in the work of music therapy / oncology: the aspect of gender: Do female and male cancer patients differ in the way in which they approach music therapy and how they deal with it – and if they do so: to what extent? The severity and finality of the diagnosis of cancer on the one hand and the facts that music as a therapeutic agent appeals to human emotionality, expressivity and communicative competence and that music therapy stimulates an active and creative way of coping with illness on the other hand leads to the assumption that patients differ in their ways of responding to this offer. It is an important research problem to what extent this response is related to gender and influences gender specific ways of coping with illness.

This problem is in the focus of a research project of the Master’s course on music therapy which has been going on for two years (a pilot project for generating hypotheses, a first project based on collecting data in one clinic in Hesse, a second project based on collecting data in clinics in other states in Germany). The research is centred around selected music productions of equally distributed female and male patients (and their therapists) which mark a certain level of development in their illness and treatment processes. The analysis of these productions makes use of a phenomenological-hermeneutic procedure (a morphological description
with slight modifications) which has worked well in the past, and a number of variables of setting like space, time (number, duration and frequency of sessions), choice of instruments, work with relatives etc. are taken into account. This approach of qualitative research in the field of psychotherapy is combined with a quantitative measurement technique on the state of psychological well being which is administered before and after the treatment (Baseler Befindlichkeits-Skala).

Besides the just mentioned research on the music related parts of the therapeutic encounter we are engaged in a sequential analysis of the verbal interaction in the sessions of music therapy. All the work in music therapy is embedded within a verbally structured frame of interaction. This can be limited to a short sequence of mutual greeting in the beginning and of parting in the end, but it can also consist of extended sequences of conversation in which the musical interaction is being commented on or reflected or even generates a primarily verbal psychotherapeutical process of self-realization. It is necessary that these sequences of verbal interaction are analysed in their own right. The analysis of verbal interaction will proceed in the following steps:

1. The audio recordings will be transcribed on the basis of a transcription system of an intermediate exactitude. Thereby a data basis will be established which will make it possible to reconstruct the meaning context of verbal interaction and to grasp the subjective ascriptions of meaning of the interaction partners beyond the literal lexical sense of utterances.

2. The verbal interaction will be descriptively and sequentially paraphrased, i.e., the unfolding of the manifest, thematic structure of the interaction will be grasped and described. What are both interaction partners focussing at in their initial encounter? How do they accomplish the transition to the musical therapeutic part of their interaction? How do constitutive conditions of interaction (the conditions which are related to the specific institution, to the illness etc.) come into play and impact on the encounter?

3. After such a description of the manifest substance of the text the next step will be the extensive interpretation of meaning of the transcrip-
tions. We will make use of the procedures of the reconstruction of latent meaning structures of interactively produced texts which had been developed by Oevermann et al. (cf. Oevermann, Ulrich et al. (1979), Die Methodologie einer „objektiven Hermeneutik“ und ihre allgemeine forschungslogische Bedeutung in den Sozialwissenschaften. In: H.G. Soeffner, ed.: Interpretative Verfahren in den Sozial- und Textwissenschaften. Stuttgart: Metzler, pp. 352-434). A basic assumption of this research tradition consists in a differentiation of two levels of reality: the subjectively intentional meaning of the producers of a text on the one hand and the objectively reconstructable latent meaning structure of a text on the other hand. The extremely microscopic and sequential process of a reconstruction of meaning is especially focussing on formal features of the spoken language: the How is a key to the latent meaning structure of what has been said. The detailed analysis proceeding sentence by sentence will be pushed to a point where plausible hypotheses can be formulated which integrate the perceived specificities of the texts and make sense of them.

Finally these three levels of analysis will be confronted with the results of the descriptions of the music productions in order to look for compatibilities or possibly interesting contradictions.

The research team consists of “local” practitioners, i. e. music therapists documenting their music therapeutic-oncological practice and sharing their material as well as their specific knowledge on the substance matter and on patients in a collegial discourse, and a circle of further music therapists who are engaged in a “blindfold experiment” of analysing the music productions without knowledge of the whole research context. Another group of experts is responsible for the processing and analysis of the data and the theoretically informed interpretation: This group consists of a female and a male music therapist and the two chairpersons of the Master’s course on music therapy (Professor Dr. Almut Seidel and Professor Dr. Birgit Gaertner).
Contact:

Fachhochschule Frankfurt am Main-
University of Applied Sciences
Der Präsident
Referat Weiterbildung
Nibelungenplatz 1
60318 Frankfurt
Tel. 069 / 1533-2681
Fax: 069 / 1533-2683

Information can be obtained by contacting: seidel@fb4.fh-frankfurt.de

Information on the Web (German)
http://www.fh-frankfurt.de/design98/wwwwb/musik/musiktherapie.htm

Dancing in the dark’ - some thoughts about a research symposium at the University Witten/Herdecke

Julie Sutton

“When the darkness engulfs us, none of us know how we shall respond. Whether we are called to face a terminal illness, the death of one we love more than life itself, the breakdown of a marriage or the desolation of an unrequited love, a parent with Alzheimer’s or the loss of a job, dancing in the dark is the hardest dance, and many of us are defeated by it.”¹

At first reading, this might seem to be a rather dark quotation to place at the beginning of a short article about a symposium, but as anyone who

has engaged in the research process will testify, as well as illumination, there are indeed some dark places along the path followed by the researcher. And the experience of proposing, undertaking and writing a PhD thesis is one of the hardest dances we can join. It often begins enthusiastically, with a great deal of energy, but usually slows down considerably when the reality of the project dawns upon the researcher. It is a very big and a very long dance, where the choreography can change unpredictably, and where it is impossible to hold a sense of the whole dance in your head. It is very easy to lose your footing, and sometimes one’s feet ache, or feel heavy and slow. Even with encouragement and support, no-one else can do it for you. It is an essentially solitary dance.

When invited by Professor David Aldridge to attend the July 2003 research symposium at the University of Witten-Herdecke, Germany, my first thoughts brought me back to my own, lonely PhD experience. The previous year I had also attended a similar event at Aalborg University, Denmark, where music therapist researchers shared their thoughts, discoveries and questions, with each other and also with experienced researcher supervisors. In Aalborg I had been both inspired and refreshed by the respectful thinking-together undertaken, at the centre of which was the unfolding dance – each single PhD project. I realised that to present one’s work in the company of fellow researchers was one effective way of breaking the researcher isolation, and to dance in the company of others.
At the symposium in Witten there were many different dancers and dance genres, because this was a showcase for researchers from all kinds of professions related to complementary medicine. As well as music therapists, I heard presentations from nurses, psychologists and other creative arts therapists. I wondered, from my own point of view, if it would be possible to join so many different dances. I might well find myself left in the dark, particularly as most people presented in a language in which I have limited fluency. To digress, I feel that this issue of language is significant. Many music therapist researchers in Europe (and from further afield) have to adopt an agreed scientific language of English, depending on where their research is registered. Others have made a conscious decision to write in English, because of a belief that this is the only real way join the international research community. If English is your native tongue there should be no problem. Yet, the writing of a PhD thesis (that is, the grounding of the investigation, the reporting of results, and the conceptual thinking and theory-building that follows) is a far from easy task, even in one’s first language. The task is far more challenging in a second or third language. This was the case for some of the researchers I heard over the two days, when several colleagues spoke in fluent English, while owning another first language. It was a strange experience, trying to understand some
presentations in German, and then listening to others in my native language, spoken by those whose first language was German. I recalled my experiences of teaching students who were native English speakers and compared these with teaching students who had another first language. With the native English-speakers I begin on an equal footing, of a shared language. With the other students there is an unequal power balance that can be felt from both sides. (I experienced one wonderful example of this recently, when I was teaching in another country. At the end of the final afternoon, the students discussed something with great intensity in their native tongue, while I was left in the dark, fantasising that perhaps they were deciding how boring their three days of my seminars had been. In fact, they were checking urgently amongst themselves that they had all contributed to the gift I was about to receive.) This reminded me that not just knowledge is power, but that there is power in the language you use, and the clarity and ease with which you use it.

In discussing this further with colleagues who are writing their theses in another language, it became apparent that it was a complex as well as a challenging task. For instance, much of the terminology and conceptual thinking of one native German had been completed in English. In one sense it was untranslatable into her native tongue, because some of the theoretical terminology did not exist in the other language. She noted that she often thought in English when working on the thesis. Another researcher reported that he thinks and writes first in his native tongue, and then begins the painstaking process of translating his work into good-enough English. These experiences are not uncommon, and while such researchers might already be part of an excellent nurturing network stemming from within their university, there is less support available for them in terms of writing in another language. I discovered that such support
was often sought and found within a circle of colleagues who were also friends, and that it was essentially an informal arrangement.

Perhaps there is potential for a resource, of an identifiable group of colleagues who are willing to support peers embarking on thesis-writing in their second or third language? The potential and the reality are two different things, however. For the supporting colleague this can be a big responsibility, and there are dangers lurking behind the researcher/language supervisor liaison. It is important to acknowledge the delicacy of such a task. It would be useful to ask the obvious question: ‘what could this offer and it is possible to safeguard the whole process, for both parties?’ A series of working rules would be essential. The setting of a contract (formal or otherwise) is important, in order for both researcher and supporting peer to be clear about who has the ultimate responsibility for the thesis. The language supervisor can offer thoughts and responses, but the judgment and taking of advice offered has to be the duty of the PhD candidate. For the language supervisor, while time-consuming, the work offers the opportunity to become acquainted with a thesis in depth and detail. This could be attractive for someone working in a similar field.

Clearly, this kind of dancing is not a simple matter. However, as well as bringing challenges there are rewards, for while the translation process is never clear-cut, paradoxically, the added perspective of another language can further focus the mind in terms of conceptual thinking. I wondered if these translating researchers did not complete two ‘dances’, one from their own culture and another for the required thesis examination (i.e. the submission and subsequent questioning from examiners). If not actually dancing in the dark, then these researchers certainly had to supply and carry their own torches.
Returning to the symposium, it became apparent very quickly that it was not only possible, but also easy to join so many different dances. While the topics were unrelated to my own areas of expertise, this in itself enabled the actual process of research to become clear. With music therapy research presentations I tend to centre my thinking on the topic itself, with the research process a secondary consideration. The symposium was stimulating for me because it clarified the ways in which the refining of the initial research questions, the choice of methodology, the task of the literature search, and the formatting of findings are found in any thesis. While the dance differed, what the dancer did was essentially the same. As with all creative acts, there is potential for new insight when something is viewed from different perspectives. Some examples of this were found in projects as diverse as re-viewing pain management in a hospital setting, analysing colour choices for medical internet sites, and implementing a behaviour programme for families with children whose behaviour was challenging to those around them. I also heard presentations about early interaction, song-based work with autistic children, and work with those with multiple sclerosis and others in a neuro-rehabilitation setting. A total of eleven presentations in two days, each at a different stage in the research process. In every case the necessary decision-making and
clarification of thinking was apparent. The methodological choices, while varied, where pertinent to any researcher, and the individuality of each project and researcher was evident. Viewing many projects over a short period of time highlighted the individual experience of the researcher. I found great value in the periods of time away from the necessary formality of presenting research, when informal discussion took place and we reflected upon the research process in other ways.

As I knew from my own experience, a PhD is a particularly personal piece of work - a single, lengthy, solo dance that we create, for ourselves. David Aldridge is one of the few publishing researchers who has acknowledged this personal investment, and he contextualised this very well when he wrote:

‘Doctoral studies are focused on the development of the doctoral candidate. They are there for the sole process of developing someone who will later be able to carry out research. Therefore
the work itself will often be on an intensely deep and inward-looking nature.”

In my informal conversations, it was striking but perhaps not surprising to discover that while researchers chose their topic for a variety of reasons, it is often a trail of events, desires and unconscious personal motivations guiding this choice. Frequently research topic choices are linked not only with clinical work, but also with a life history. Just as within clinical work, the personal histories of researchers can be exposed, and it is this personal investment that can make the PhD process so intense.

To summarise my experience of the 2003 Witten research symposium, I found that observing so many colleagues format and present their research to a high academic and technical level was both fascinating and stimulating. A certain energy invades a building when we gather together to talk about our research.

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This energy reflects the individual motivation and drive necessary to complete a PhD. For me, it is this exchange of ideas and experiences that is so vital to research in general, and also to practising and student researchers. Within an international forum, the exchange is broader and wider, and, as I explored a little earlier, the issue of language becomes more critical. This is a significant area for those writing in a second or third language, but even if you are writing in your native tongue, you still engage in the process of translating your experiences, reflections, ideas and findings. In my opinion, it is not the sophistication of the language, but the way we communicate simply and clearly that is important. Karl Popper wrote:

“…spectacles have a function, and they function only when you put them on, to look through them at the world. It is the same with language. That is to say, one shouldn’t waste one’s life in spectacle-cleaning or in talking about language, or in trying to get a clear view of our language, or of ‘our conceptual scheme’. The fundamental thing about human languages is that they can and should be used to describe something; and this something is, somehow, the world.”¹

But perhaps the best advice for the translating researcher, as for anyone beginning the long research dance, is, to borrow a short phrase from my own community:

“if ye can’t schemey ye must louster, and tes better to have a spare umbrella than a spare bedroom”².

A rough translation from this Cornish dialect (incidentally, my own first language) would be, ‘it’s best to work hard and be prepared for the unex-

² Penrose (1995) How To Be Proper Cornish UK Penzance, Headland Printers p10
“schemey” = to plan out, to aspire to brain work; “lowster” = to do hard labouring work
pected’. Interestingly, this could also be the work of the dancer, whether
dancing in the dark or the light.

I would like to acknowledge the support of David Aldridge, Simon Gil-
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This issue looks at music therapy in practice and a need for such practice to be based on a foundation of research.

When I was at the 2001 Cochrane conference in Lyon, I came into contact to this sect of the scientific community for the first time. I was surprised how many statisticians were there and how they were behaving like new popstars in the research scene. At dinner table, I was given a crash course from a young researcher about good and methodologically sound scientific work, which consists notably of randomised or clinical controlled trials. I was wondering how she could know this with such certainty and whether she had heard of the social science and philosophy of science debates about intersubjectivity, critical theory and positivism, constructivism, social identity, grounded theory, and the myriad of other problems arising in trying to understand the human condition and health care delivery. She replied that all this sounded very subjective, that expert perspectives are a source of bias and probably contaminate "clean" reviews of published scientific work. "All we need", she said, "is trails." A colleague then sang a Cochrane version of the famous Beatles song "All you need is love". rewritten as "All you need is trials".

FIGURE 1.
ALL YOU NEED IS TRIALS!

Nothing you can search that can’t be found
Nothing to include that isn’t sound
Don’t hypothesise, better meta analyse
It’s easy
All you need is trials

Don’t forget to weight for sample size
Don’t forget your peers should criticise
Don’t forget, be true, there’s just one man for you
It’s Rev Man
All you need is trials

Don’t forget it’s time for that update
Don’t forget you must disseminate
Nothing’s worth the fuss, if it’s going to gather dust
It’s easy
All you need is trials

Please don’t let your ego overheat
Please don’t think you’re part of an elite
It just becomes hot air, if you forget to care
It’s easy
All you need is LOVE

Lennon J 1966 (Personal communication)

Annemiek Vink, in her presentation at the 2002 Oxford conference, proposed a
model of Evidence based music therapy and discusses how this can be applied within the music therapy profession. She proposes that the Cochrane library provides a considerable source of references that helps to compare treatment strategies.

To get an impression of how controversial this debate is I would like to invite you to read the following article. Expertise is not evidence but in the healing relationship it is paramount" says David Aldridge in his article "Staying close to practice: Which evidence, for whom, by whom". He argues that we need an approach to music therapy research that stays close to the practice of the individual clinician; that is, the musician as therapist. Each therapeutic situation is seemingly unique. Yet, we compare our cases and share our knowledge with each other. Research methods are means for formalising our knowledge so that we can compare what we do. Another presentation from the Oxford 2002 Conference comes from Simon Gilbertson. In his paper Growing Roots: Music Therapy in Neurosurgical Rehabilitation, he refers to his experience as a music therapist working in neurological rehabilitation clinic in Germany. Having established individualised instruments and techniques for patients with neurological disorders, he has always sought for an appropriate practice and research for and with the patient.

Wolfgang Schmid and his colleagues question the nature of music therapy research "Functionality or aesthetics? Music therapy as a component in an integrated medicine approach to the treatment of multiple sclerosis patients" in terms of which outcomes are relevant. They write that patients with a chronic disease are also stigmatised and this spoiled identity is further exacerbated by the concept of degeneration. Any intervention that improves mood and enhances self-acceptance is valuable in mitigating stigma and offers a contrasting perspective to research that focusses upon functional improvements alone.

Martin Kusatz has been an extensive practice as music therapist with tinnitus patients. In his article "Auditive Stimulation Therapy AST® as an intervention in subacute and chronic tinnitus" he presents results from his doctoral thesis. For the ten million sufferers in Germany alone, he offers real strategies of relief. Methodologically, he presents us with a form of clinical audit based on a
survey method that is highly applicable to music therapy research.

The short research report from Landsiedel-Anders on "Music therapy in demetia care - recent findings" gives some information on a research project conducted at the University of Frankfurt and continues our research reports started in the last issue. This article presents the results from two recent studies. The first is a summative, internal evaluation of a music therapy intervention with six seriously demented male and female inhabitants of a nursing home for the elderly, based on qualitative and qualitative approaches. The second is a clinical experimental study with dementia patients at a medium stage as part of a memory-supporting surgery, a specific outpatient facility offering diagnostics, therapy and counselling to patients suffering from dementia.

Last not least we want to offer you insights into the recently finished ESCOM Conference from 8th - 13th September 2003 in Hanover, Germany. The European Society for the Cognitive Sciences of Music has been a huge event where different music researchers meet to exchange ideas. I was fortunate enough to be asked to conduct a Symposium on Music Therapy were we heard different perspectives on music therapy. Such instances help to establish music therapy as a specialist discipline in the music sciences. Hanne Mette Ochsner Ridder was there to present her work but here she provides us with her thoughts and observations in this conference report.

Until we read again
Joerg Fachner
Functionality or aesthetics? Music therapy as a component in an integrated medicine approach to the treatment of multiple sclerosis patients

Wolfgang Schmid ¹, Thomas Ostermann ² and David Aldridge ¹

1. Institute for Music Therapy, Faculty of Medicine, University of Witten/Herdecke

2. Department of Medical Theory and Complementary Medicine, Faculty of Medicine, University of Witten/Herdecke

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Abstract

Neuro-degenerative diseases are, and will remain, an enormous public health problem. Interventions that could delay disease onset even modestly will have a major public health impact. Music therapy is being
increasingly used in the treatment of neurodegenerative diseases. In this study, twenty multiple sclerosis patients (14 female, 6 male) were involved, their ages ranging from 29 to 47 years.

Ten patients in the therapy group received three blocks of individual music therapy in single sessions over the course of the one year project (8 to 10 sessions respectively). Measurements were taken before therapy began (T1), and subsequently every three months (T2-T4). The assessment measures included indicators of clinical depression and anxiety (Beck Depression Inventory and Hospital Anxiety and Depression Scale), a self-acceptance scale (SESA) and a life quality assessment (Hamburg Quality of Life Questionnaire in Multiple Sclerosis). In addition, data were collected on cognitive (MSFC) and functional (EDSS) parameters.

There was no significant difference between the music therapy treatment and control. However, the effect size statistics comparing both groups show a medium effect size on the scales measuring self esteem (d 0.5423, r 0.26), depression HAD-D (d 0.63, r 0.310) and anxiety HAD-A (d 0.63, r 0.310). Significant improvements were found for the therapy group over time (T1-T4) in the scale values of self esteem, depression and anxiety.

Music therapy brings an improvement in mood and self-acceptance.

Keywords:

music therapy, matched control group, self-acceptance, self esteem, depression, anxiety, functional scores, aesthetic.
**INTRODUCTION**

Neuro-degenerative diseases are an enormous public health problem. These diseases are disabling to the sufferers, there is a loss of normal motor functioning, a change in mood, and a gradual loss of cognitive abilities (Amato and Zipoli 2002; Mahler and Benson 1990) including auditory problems (Armstrong 1997) and memory changes (Johnson, Deluca, Diamond et al. 1996), and sensory processing (Schurmann, BasarEroglu, and Basar 1997). These multifarious problems worsen during the course and stages of the disease (Amato and Zipoli 2002). Furthermore, the sufferer does not suffer alone, these losses have an impact upon family and social life. While there are numerous projects aimed at finding medical relief for suffering and the treatment of disease, we are reminded that these problems are also illnesses. Behaviour is influenced and this has ramifications for relationships. We are challenged as a society that people within our midst are suffering and it is our responsibility within the delivery of health care to meet that challenge with appropriate responses (Aldridge 2000).

Multiple Sclerosis is the most frequent inflammable disease of the central nerve system among young adults. It is an autoimmune disease with additional genetic and environmental factors (Gold and Rieckmann 2000) and considered to be one disease in the general class of neurodegenerative diseases.

A major confrontation for those offering treatment, as it is for the patient, is that the problem worsens and there is no cure. Furthermore, the problems facing patients confront the deepest fears of a consumer success-oriented society. Decline, physical and mental, is not readily faced within communities that expect youthful appearance, worldly success and phys-

Physical ability as the outer sign of acceptable personhood (Aldridge 2000). While medical approaches will undoubtedly focus on a functional strategy for treatment, we cannot ignore that these diseases have implications for the performance and appearance of the person in everyday life. Therefore, we need therapeutic approaches that include aesthetic performance as well as functional performance (Aldridge 1991).

The aim of this study is to see if the illness is responsive to change when treated with music therapy in contrast to a group of patients receiving standard medical treatment alone. Disease progression differs considerably from patient to patient, so that while we may talk about stages of the disease there is no typical multiple sclerosis patient but rather a heterogeneous group of patients where generalizations do not really apply (Evers and Karnilowicz 1996). As there are no curative therapeutic interventions, we are reliant upon palliative interventions. Only a limited number of studies have explored arts and music therapy, although complementary and alternative medicine approaches are being used (Alcock, Chambers, Christopheson et al. 2001; Bowling and Stewart 2003; Nayak, Matheis, Schoenberger et al. 2003; Pleines 1992; Sparber and Wotton 2002; Thorne, Paterson, Russell et al. 2002; Winterholler, Erbguth, and Neundorfer 1997) and these emphasise a whole-person approach with individualised treatment plans (Whitmarsh 2003).

Music therapy can be considered within an integrated treatment strategy for two reasons. One, it offers a means to improve communicative performance – a functional basis (Magee and Davidson 2002). Second, it promotes the presentation of a self that, although considered as handicapped or degenerating, can also be performed as satisfying and whole – and that is a matter of aesthetics (Aldridge 1991; Aldridge 1996).
According to recent publications, multiple sclerosis patients show increasing interest in complementary and alternative therapies (Alcock et al. 2001). One reason is their general disappointment with conventional medicine, since causal treatment is not possible; another is a wish to play a more active role in coping with the disease and a demand for a wider range of therapies to meet psychosocial needs as well. Sufferers say that by using a complementary medical approach then they take personal responsibility for health, reframe the measures by which therapeutics are evaluated, and adopt a pragmatic approach to living as well as possible in the context of a chronic condition (Thorne et al. 2002). Each individual will want to establish her own treatment plan.

Studies into factors governing the quality of life for multiple sclerosis patients are interesting in this context. They reveal that patients and their physicians have different perspectives. Physicians determine quality of life mainly with physical and functional parameters, while patients themselves see psychosocial well-being, emotional stability and ways to cope with multiple sclerosis-induced stress as the most important factors (Rothwell, Dowell, Wong et al. 1997). High levels of depression and anxiety are associated with people with MS who seek complementary approaches, although this may be an underlying factor of chronic illness (Sparber and Wootton 2002).

This frequently life-long process for patients, that starts when multiple sclerosis is diagnosed and requires continuous efforts to adapt to changing situations, obviously demands a range of therapeutic possibilities which must also consider and encourage a patient’s creative abilities (Kriz 1994).

Because of the nature of the disease, a chronic degeneration, then patients need an important supportive element that promotes coping processes

*Functionality or aesthetics? Music therapy as a component in an integrated medicine*
and offers an identity that is not solely that of the chronically sick (Aldridge 2003).

The music therapy literature on single or group music therapy with multiple sclerosis patients shows that there are only a few studies available. O’Callaghan (O’Callaghan 1996), for example encourages patients to write songs using expressive elements related to positive feelings for other people, memories of relationships and expressions of the adverse experiences resulting from living with the illnesses.

In a controlled pilot study Wiens et al. (Wiens, Reimer, and Guyn 1999) demonstrated a potential strengthening effect of music therapy – with a focus on breathing and speech - on the respiratory musculature of multiple sclerosis patients. Respiratory muscle weakness is characteristic of individuals with advanced multiple sclerosis and can result in repeated infections of the lung.

Group music therapy (Lengdobler and Kiessling 1989) based on experiences with a music-therapy group of 225 hospital inpatients with multiple sclerosis, who participated in a 6 week group music therapy program, offers psychological support, relieves anxiety and depression and possibly helps with the difficult process of coping with the disease individually.

Magee (Magee 1998; Magee, W 1999; Magee, W. 1999; Magee 2002), also makes use of well-known, precomposed songs and spontaneous improvisation on instruments and their attitudes change from a ‘disabled self-concept’ to a more ‘able self-concept’. In a further study, (Magee and Davidson 2002), the authors show an improvement in mood state following music therapy, although depression was not directly affected.
We have then a clinical picture of general deterioration with expectations by some sufferers that they will be able to take an active part on their therapy. We know from the limited, principally anecdotal, music therapy literature that there are potential benefits from music therapy in terms of enhancing mood and improving self-identity. What we need to establish is which of the varying parameters is subject to influence by music therapy.

**Method**

**Participants**

Twenty multiple sclerosis patients (14 female, 6 male) were involved in the study, their ages ranging from 29 to 47 years, with episodic, secondary chronic and primary chronic progression and an average disease duration of 11 years.

Ten participants formed the therapy group, and ten the control group. The groups were comparable in the standard neurological classification scheme EDSS (Expanded Disability Status Scale) (Kurtzke 1983). The EDSS of both groups was 2.6 on average, which means that the participants were between normal functions (Score:0) and disability that precludes full daily activities (score: 5.5).

Exclusion criteria were pregnancy and mental disorders requiring medication.

All participants were informed of the content and details of the study and gave their written consent to publish the material, especially the video sequences from the music therapy sessions. The protection of data privacy and the ethical aspects were examined by the Ethical Committee of University of Witten/Herdecke.
Patients were matched from the records for age, gender and staging of the disease.

**MATERIALS**

A matched control trial was implemented using a battery of indices before therapy began (T1), and subsequently every three months (T2-T4). This battery included indicators of clinical depression and anxiety (Beck Depression Inventory and Hospital Anxiety and Depression Scale), a self-acceptance scale (SESA) and a life quality assessment (Hamburg Quality of Life Questionnaire in Multiple Sclerosis). In addition, data were collected on cognitive (MSFC) and functional (EDSS) parameters.

**PROCEDURE**

The Beck Depression Inventory (BDI) is an established and reliable questionnaire for assessing the severity of depression and offers an instrument suitable to compare this study with other clinical studies (Aikens, Reinecke, Pliskin et al. 1999). The Hospital Anxiety and Depression Scale (HAD) is a self-administered, bidimensional instrument developed to screen for clinically significant depression and anxiety in medical populations (Zigmond, 1983 #657). The Scale for the Evaluation of Self Acceptance (SESA) is a 35 question scale translated from an original scale that assesses the acceptance of self and others (Berger 1952). The Hamburg Quality of Life Questionnaire in Multiple Sclerosis (HAQUAMS) is a disease specific quality of life instrument for MS. There are 38 items about physical, psychological and social functions and questions about symptoms, progression of the disease and general impairment (Gold, Heesen, Schulz et al. 2001). The EDSS describes the state of disability of an MS-patient and ranges from 0 (=normal) to 10 (=death due to MS). It is a classification scheme that insures all participants in clinical trials are in the same class, type or phase of MS (Kurtzke 1983). It is also used by neurologists to follow the progression of MS dis-
ability and evaluate treatment results. Because of its strong emphasis on ambulation, the EDSS is insensitive to changes in other neurological functions and to cognitive dysfunction in MS. The Multiple Sclerosis Functional Composite (MSFC) is a multidimensional instrument to assess disability of MS-patients. It has three parts, testing the function of legs and walking-ability, the functions of arms and hands and the cognitive functions (Fischer, Rudick, Cutter et al. 1999).

The patients in the therapy group received three blocks of music therapy in single sessions over the course of the project (8 to 10 sessions respectively).

The music therapy approach used for this study is based on the Nordoff Robbins approach (Nordoff and Robbins 1977). Both patient and therapist are active. Music-making on instruments, or singing, and the music itself that emerges, all are potential possibilities for activity, encounter and experience. Individual themes and musical developments emerged for each individual patient; some wanted to sing and dance, others wanted to be sung to, and others wanted to play an instrument or brought their own instruments with them. There were no expectations of previous musical education. The patients wanted recordings of their sessions and their individual selections were recorded onto compact discs. They played them to their partners or friends or just listened to some pieces and remembered the condition and feelings of the situation.

Results

There was a high degree of willingness on the part of all patients to take part in the study, so that all rounds of interviews were completed, and 85% of all music therapy sessions took place.
At the start of the study (T1) there was no significant difference between therapy group and control group on the varying scale measures. At the final assessment stage (T4), there was no significant difference between the music therapy treatment group and the control group EDSS $p = .678$, MSFC $p = .990$, SESA $p = .241$ BDI $p = .414$ HADS-A $p = .0162$, HADS-D $p = .162$, HAQAMS $p = .116$) (see Table 1). However, the effect size statistics comparing both groups show a medium effect size on the scales measuring self esteem ($d = 0.5423, r = 0.26$), depression HAD-D ($d = 0.63, r = 0.310$), and anxiety HAD-A ($d = 0.63, r = 0.310$).

<table>
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<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
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<tr>
<td>Matched control</td>
<td>10</td>
<td>.1330</td>
<td>.5401</td>
<td>1708</td>
</tr>
<tr>
<td><strong>JCS T4 Music therapy</strong></td>
<td>10</td>
<td>30.90</td>
<td>17.71</td>
<td>5.60</td>
</tr>
<tr>
<td>Matched control</td>
<td>10</td>
<td>31.60</td>
<td>16.55</td>
<td>5.23</td>
</tr>
<tr>
<td><strong>SESA T4 Music therapy</strong></td>
<td>10</td>
<td>121.80</td>
<td>13.0282</td>
<td>4.1199</td>
</tr>
<tr>
<td>Matched control</td>
<td>10</td>
<td>111.20</td>
<td>24.3758</td>
<td>7.7083</td>
</tr>
<tr>
<td><strong>BDI T4 Music therapy</strong></td>
<td>10</td>
<td>6.1000</td>
<td>5.2589</td>
<td>1.6630</td>
</tr>
<tr>
<td>Matched control</td>
<td>10</td>
<td>9.7000</td>
<td>12.5614</td>
<td>3.9723</td>
</tr>
<tr>
<td><strong>HADSA T4 Music therapy</strong></td>
<td>10</td>
<td>4.5000</td>
<td>2.9907</td>
<td>.9458</td>
</tr>
</tbody>
</table>
| Matched control       | 10 | 6.8000 | 3.9944        | 1.2632          

*Functionality or aesthetics? Music therapy as a component in an integrated medicine*
TABLE 1. A Group comparison at final test (T4).

<table>
<thead>
<tr>
<th></th>
<th>Matched control</th>
<th></th>
<th>Matched control</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>HADSD T4 Music therapy</td>
<td>10</td>
<td>2.5000</td>
<td>.7782</td>
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<tr>
<td>Matched control</td>
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<td></td>
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<tr>
<td></td>
<td>10</td>
<td>4.9000</td>
<td>1.4488</td>
<td></td>
</tr>
<tr>
<td>HADSD T4 Music therapy</td>
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<td>1.1216</td>
<td></td>
</tr>
<tr>
<td>Matched control</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend: EDSS Expanded Disability Status Scale; MSFC Multiple Sclerosis Functional Composite; JFFS Fatigue Scale of the JCS Incapacity Scale; SESA Scale for the Evaluation of Self Acceptance; BDI Beck Depression Inventory; HADSA Hospital Anxiety and Depression Scale - Anxiety; HADSD Hospital Anxiety and Depression Scale - Depression; HAQUAMS Hamburg Quality of Life Questionaire in Multiple Sclerosis

Table 1 B Group comparison at final test (T4).

<table>
<thead>
<tr>
<th>Final test</th>
<th>Levene’s-Test for Equality of Variances</th>
<th>t test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>EDSS</td>
<td>.108</td>
<td>.747</td>
</tr>
<tr>
<td></td>
<td>.406</td>
<td>.033</td>
</tr>
<tr>
<td></td>
<td>.003</td>
<td>.960</td>
</tr>
<tr>
<td>JCS</td>
<td>.321</td>
<td>.087</td>
</tr>
</tbody>
</table>


Table 1 B  Group comparison at final test (T4).

<table>
<thead>
<tr>
<th></th>
<th>Equal variances not assumed</th>
<th>1.213</th>
<th>13.754</th>
<th>.246</th>
<th>10.6000</th>
<th>8.7402</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>Equal variances assumed</td>
<td>4.825</td>
<td>.041</td>
<td>-.836</td>
<td>18</td>
<td>4.3063</td>
</tr>
<tr>
<td></td>
<td>Equal variances not assumed</td>
<td>-.836</td>
<td>12.061</td>
<td>.419</td>
<td>-3.6000</td>
<td>4.3063</td>
</tr>
<tr>
<td>HADSA</td>
<td>Equal variances assumed</td>
<td>.454</td>
<td>.509</td>
<td>1</td>
<td>1.458</td>
<td>1.5780</td>
</tr>
<tr>
<td></td>
<td>Equal variances not assumed</td>
<td>-</td>
<td>1.458</td>
<td>16.678</td>
<td>.164</td>
<td>1.5780</td>
</tr>
<tr>
<td>HADSD</td>
<td>Equal variances assumed</td>
<td>4.142</td>
<td>.057</td>
<td>1.459</td>
<td>18</td>
<td>1.6445</td>
</tr>
<tr>
<td></td>
<td>Equal variances not assumed</td>
<td>-</td>
<td>1.459</td>
<td>13.794</td>
<td>.167</td>
<td>1.6445</td>
</tr>
<tr>
<td>HAQUA</td>
<td>Equal variances assumed</td>
<td>313</td>
<td>.583</td>
<td>1.652</td>
<td>18</td>
<td>.1671</td>
</tr>
<tr>
<td>MS</td>
<td>Equal variances not assumed</td>
<td>1.652</td>
<td>17.938</td>
<td>.116</td>
<td>.2760</td>
<td>.1671</td>
</tr>
</tbody>
</table>

Legend: EDSS Expanded Disability Status Scale; MSFC Multiple Sclerosis Functional Composite; JFFS Fatigue Scale of the JCS Incapacity Scale; SESA Scale for the Evaluation of Self Acceptance; BDI Beck Depression Inventory; HADSA Hospital Anxiety and Depression Scale - Anxiety; HADSD Hospital Anxiety and Depression Scale - Depression; HAQUAMS Hamburg Quality of Life Questionaire in Multiple Sclerosis

Significant improvements were found within the therapy group over time (T1-T4) in the scale values of SESA $p=0.012$, for depression (BDI $p=0.036$, HADS-D $p = 0.035$) and anxiety (HADS-D subscale anxiety $p = 0.13$) (see Table 2.).
TABLE 2. Within group significant differences over time (Wilcoxon Test)

<table>
<thead>
<tr>
<th></th>
<th>EDSS T4-T1</th>
<th>MSFC T4-T1</th>
<th>SESA T4-T1</th>
<th>BDI T4-T1</th>
<th>HADS-A T4-T1</th>
<th>HADS-D T4-T1</th>
<th>HAQUAMS T4-T1</th>
</tr>
</thead>
<tbody>
<tr>
<td>MT</td>
<td>z</td>
<td>-1.194</td>
<td>-.105</td>
<td>-2.499</td>
<td>-2.100</td>
<td>-2.492</td>
<td>-2.105</td>
</tr>
<tr>
<td></td>
<td>Asym.sig.</td>
<td>.233</td>
<td>.917</td>
<td>.012</td>
<td>.036</td>
<td>.013</td>
<td>.035</td>
</tr>
<tr>
<td>Control</td>
<td>z</td>
<td>-1.482</td>
<td>-1.482</td>
<td>-.255</td>
<td>-1.819</td>
<td>-2.154</td>
<td>-1.367</td>
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<tr>
<td></td>
<td>Asym.sig.</td>
<td>.660</td>
<td>.138</td>
<td>.798</td>
<td>.413</td>
<td>.031</td>
<td>.172</td>
</tr>
</tbody>
</table>

Legend: EDSS Expanded Disability Status Scale; MSFC Multiple Sclerosis Functional Composite; JFFS Fatigue Scale of the JCS Incapacity Scale; SESA Scale for the Evaluation of Self Acceptance; BDI Beck Depression Inventory; HADSA Hospital Anxiety and Depression Scale - Anxiety; HADSD Hospital Anxiety and Depression Scale - Depression; HAQUAMS Hamburg Quality of Life Questionaire in Multiple Sclerosis

FIGURE 1. Effect size comparisons of within group changes over time (pre-test and final test)
These improvements can be compared as effect sizes. We see a considerable effect between the beginning of therapy and the end of therapy (see Figure 1) on improving self esteem (SESA) and relieving depression (BDI).

When we consider the correlations between the scale scores differences between T1 and T4, we find that there are significant correlations between the HAD depression index and self-acceptance, and depression on the BDI and HAD anxiety and depression (see Table 3).

**TABLE 3. Correlation of the differences in scales between T1 and T4.**

<table>
<thead>
<tr>
<th>Spearman-Rho</th>
<th>SESA Corr. coefficient</th>
<th>BDI</th>
<th>HADA</th>
<th>HADD</th>
<th>HAQUAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SESA</td>
<td>1,000</td>
<td>-.367</td>
<td>-.332</td>
<td>-.611**</td>
<td>.033</td>
</tr>
<tr>
<td>Sig. (two-tailed)</td>
<td>,</td>
<td>.111</td>
<td>.153</td>
<td>.044</td>
<td>.891</td>
</tr>
<tr>
<td>N</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>BDI</td>
<td>1,000</td>
<td>.566**</td>
<td>.493*</td>
<td>.127</td>
<td></td>
</tr>
<tr>
<td>Sig. (two-tailed)</td>
<td>,</td>
<td>.009</td>
<td>.027</td>
<td>.594</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>HADSA</td>
<td>** 1,000</td>
<td>.411</td>
<td>.118</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (two-tailed)</td>
<td>,</td>
<td>.072</td>
<td>.619</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>HADSD</td>
<td>** 1,000</td>
<td>.011</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (two-tailed)</td>
<td>,</td>
<td>.965</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>HAQUAMS</td>
<td>1,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (two-tailed)</td>
<td></td>
<td>.965</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

**Correlation is significant at the level 0.01 (2-tailed).**

* Correlation is significant at the level 0.05 (2-tailed).

Legend: EDSS Expanded Disability Status Scale; MSFC Multiple Sclerosis Functional Composite; JFFS Fatigue Scale of the JCS Incapacity Scale; SESA Scale for the Evaluation of Self Acceptance; BDI Beck Depression Inventory; HADSA Hospital Anxiety and Depression Scale - Anxiety; HADSD Hospital Anxiety and Depression Scale - Depression; HAQUAMS Hamburg Quality of Life Questionaire in Multiple Sclerosis

Significant differences were found for the control group in regard to the subscale anxiety (HADS-A $p = 0.031$), while the values for depression and self-acceptance did not show any significant differences over time (T1-T4). No differences were found for the functional and physiological values (MSFC, EDSS) and quality of life (HAQUAMS). The latter is probably because the HAQUAMS quality of life is mainly assessed from statements of physical well-being and mobility thus reflecting scores on the functional scales.

**Discussion**

The significant positive changes in mood are also reflected in the self-acceptance scale. Given that patients with a chronic disease are also stigmatised (Goffman 1963), and this spoiled identity is further exacerbated by the concept of degeneration (Aldridge 2003), then any intervention that improves mood and enhances self-acceptance is valuable in mitigating stigma. We know from the anecdotal literature that music therapy is important for establishing and recreating self identity (Aldridge 1989; Aldridge 1996; Magee, W 1999). Perhaps we should not simply consider these diseases as neurodegenerative but as dialogue-degenerative diseases, where there is a breakdown in dialogue between the sufferer and the community (Aldridge 2003).
There were no recognizable changes in motor and functional abilities. The form of creative music therapy used here is efficacious for promoting a positive self identity and relieving the emotional burden on a patient.

Significant improvements in patients of the therapy group with regard to relieving anxiety and depression, and above all with regard to improved self-acceptance, are a consequence of the qualitative changes brought about in music therapy encounters. The significant change in the subscale anxiety of the HADS-A in both groups may be an indication that regular professional patient care helps reduce anxiety in multiple sclerosis sufferers. Standard therapeutic practice is that patients only attend for contact with a practitioner or treatment when there is a flare up in symptoms. Being recruited into a trial and being regularly assessed is perhaps an important variable to consider in therapeutic contact. Regularly asking someone how they are, in a careful and considered way, is perhaps a therapeutic intervention in itself.

The importance of therapeutic contact is reflected in a qualitative analysis of the data. Two hundred and twentysix music therapy sessions were documented on video and evaluated with the help of episodes and generation of categories (Aldridge and Aldridge 2002). What emerged from the qualitative aspects of the study were parameters concerning contact between therapist and patient, coping with the situation, the sharing of musical roles, an ability to structure time and the possibility to initiate changes in play. These factors reflect the needs of these patients for a deeper personal contact, a recognition of their abilities rather than pathologies and a possibility for them to exercise their own agency.

In a final interview, nine out of ten music therapy participants in the study described how important it was to become personally active in their

Treatment. All ten participants reported an immediate improvement in their well-being during sessions. In eight participants, this improved state continued for some time and was confirmed by partners or friends. This is also confirmed by improvements in the self-acceptance and depression scales but not by quality of life scores. Differences over time in the depression scores and self-acceptance scores are highly correlated with each other that may reflect their common conceptual background. Seven participants described an enhanced perception of themselves with an increasing self-confidence over the course of the therapy. They were increasingly able to let themselves be surprised by the music as it emerged and by their own previously undiscovered musical skills. Music and music therapy are experienced by patients as “something moving” that shifts negative thoughts about the disease into the background and offers a means of expression for feelings of security, freedom and pleasure (Schmid 2003). One participant relates how she met a friend in the University that she had not seen in a long time, after treatment. They talked for a while and it was only on parting that she told her friend that she has multiple sclerosis. This was a shift in her perception of herself as first and foremost “a sick person” to a normal person with other priorities in life.

What is evident from this study is that in assessing music therapy in terms of meeting patients needs then we cannot simply take a functional approach alone. Multiple sclerosis patients have a variety of needs, some of these are psychosocial and some of these are also aesthetic. An aesthetic therapy offers the opportunity to experience the self not as solely degenerative but also as creative. This is a major turn around in self-understanding and is reflected in both self-esteem and an improvement in mood. We are not denying that these patients have a degenerative disease, simply that these patients are not themselves degenerate. In the face
of pathology, even in sickness, we have the potential to be active creative agents. Music therapy emphasises creative dialogue in the face of a dialogic degenerative disease (Aldridge 2003). In that dialogue we feel better – it is as simple as that. We do not deny the physical problems involved and the functional consequences that follow. What we can offer, and what patients demand, is that we see participants as capable and creative.

References


Evidence Based Music Therapy

Vink, A.; Bruinsma, M.

Abstract

Evidence Based Music Therapy is a method in which the music therapist, in each decision he or she makes, tries to integrate best available scientific evidence with his or her own experience, combined with the values, expectations and wishes of his or her patient. Evidence Based Music Therapy is based on the principles of Evidence Based Medicine. A Systematic Review is a summary of the medical (or Music Therapy) literature that uses explicit methods to perform a thorough literature search and critical appraisal of individual studies and that uses appropriate statistical techniques to combine these valid studies.

Introduction

(The following paper was presented at the 2002 WFMT Conference in Oxford, UK.)
In this paper we will try to explain the principles of Evidence Based Music Therapy (EBMT). We will discuss criticisms that Evidence Based Medicine (EBM) has evoked. We will distinguish criticisms based on misunderstandings from those based on limitations of EBM. Our goal is to introduce EBMT as a music therapeutic method, set out the prerequisites for practising EBMT and highlight the role of systematic reviews in EBMT.

A Cochrane review is a systematic review in which relevant best practice research is summarized. The central topic of this paper will be to explain what a systematic review is and what the possible benefits are for music therapy practice, in line with current ideas of Evidence Based Medicine. At the moment, we are both involved in writing a Cochrane review about the effects of music therapy with demented elderly: “Music Therapy in the care of people with dementia”, together with Dr. R. Scholten of the Dutch Cochrane Collaboration. We will not focus on the contents of this review in-depth, as these results will be presented through the web later this year. Rather, we would like to use this review in this paper as an example to help you understand what a systematic review is and what benefits it may hold for you in evaluating research.

We will look back, what the past has taught us. Typical for the music therapy past is that we tended to theorize on our own. In terms of establishing music therapy evidence, we tended to ground our methods by referring to the Bonny method or the Priestley method. Most research and descriptive articles tended to be reflective of a way working of a particular therapist.

We also want to take a closer look in the here-and-now of music therapy: the necessity that we need to establish an evidence-based way of work-
ing. Inherent to human being, we also want to know what the future may holds for us.

Therefore, we would like to elaborate with you some new ideas of evidence based music therapy, which Manon Brusima has developed based on practice implementations. Some of you may have already read about evidenced based medicine, for instance in the special congress edition of the British Journal of Music Therapy. The number of articles in general healthcare that discusses the value of Evidence Based Medicine is accumulating rapidly. In the second section of this paper, we want to discuss examples of the implementation of EBM-principles in music therapy practice.

Music Therapy Timeline ... 1900.....1950.... ... ...1970 ... ... .2002......... ... ... ........ ... ... 

But first, let us go back in the past on the music therapy time line, or in some cases regretfully, still the present day situation. As a music therapist you are faced with the question of demonstrating the effectiveness of music therapy. First of all, to yourself, to evaluate your own way of working, but also there is the necessity to demonstrate the effectiveness to others. How did or in some cases still do we do this?

We read in our scarce time research reports, but we often do not have the time nor the knowledge to understand them in-depth. Tony Wigram pointed out during the congress: music therapists are not paid to be researchers nor do they have to be.

To help colleagues understand the value of music therapy, we often organize workshops for our co-workers and discuss a lot with other colleagues: all with the purpose of explaining and demonstrating the
effectiveness of music therapy. Luckily, other music therapists understand the topic. But, then there still is the struggle to explain it to other healthcare disciplines what music therapy is all about. This often takes years. In most cases, the value of music therapy in a certain facility tends to correlate strongly with the years of working experience. You were the person that demonstrated music therapy effectiveness. Times are changing fast and also healthcare does, which raises new demands for being a music therapy practitioner.

To end the past: we all know THAT music therapy works from our own experiences with single patients or groups in our own practice. But...how can we provide adequate ‘evidence’ for music therapy, also to other disciplines and policy makers? This question is typical for the present day situation.

If we would describe the music therapy timeline further, then a classifying characteristic would be for the present day situation that treatment should be evidence based: we need to demonstrate the effectiveness of our therapy. Not anymore by talking about music therapy’s effectiveness, but by referring to existent research materials.

Luckily, with the arrival of the Internet both patients and therapists have easy access to millions of pages concerning both general healthcare and music therapy, whereas music therapy books were generally hard to find in the past in the local libraries.

But as a music therapist how can I demonstrate effectiveness, I do not have the time nor the knowledge? This is in essence how the Cochrane review, also known as a systematic review, can be used as a helpful tool to keep your knowledge up-to-date. In a nutshell, the Cochrane review screens all good quality researches, selects the best and summarizes its
Evidence Based Music Therapy


results, which you can implement in practice. Since 1993 the Cochrane Collaboration has invested in gathering knowledge how to combine conducted researches worldwide, involving the same topic.

Going through the music therapy literature, already many literature reviews have been published. Many books contain reviews about research outcomes relevant for music therapy. You might want to refer to these reviews, but in terms of establishing evidence these reviews are often not useful. If we look more carefully at the current literature reviews, we often see that an expert has been invited to write about a certain topic, which might have biased the review. A specific research question is often absent or subjective, which might again bias the conclusions derived in the review. Often the criteria are not outlined in the review why and how the discussed research studies were included. Or what methods did the author use to judge the quality of the included research studies? Often we see that there are many possible sources of bias, which makes it difficult to fully comprehend the conclusions presented in the review. The conclusions may be subjective and might be reflective of the author’s personal interest or theoretical background and also cultural factors may have influenced the nature of the conclusion. Working in the field of music therapy, I know for myself as a fact how easily you can be driven towards subjective descriptions. Especially, in the field of music therapy you tend to take an offensive point of view in your writings. This was also the case when I wrote the first protocol versions of the dementia review. I was rightfully corrected by the Cochrane editorial board, that I introduced bias by stating that music therapy IS effective instead of MIGHT be effective, until research shows otherwise… Objectiveness should be our critical guide in evaluating, conducting and interpreting research. But how to go about? The great amount of subjectivity in eval-
Evaluating research was exactly the purpose that Archie Cochrane mentioned in 1979 that:

“It is surely a great criticism of our profession that we have not organised a critical summary, by specialty or subspecialty, adapted periodically, of all relevant randomised controlled trials.”

Following Archie Cochrane, the building blocks of a good systematic review should be the comparison of randomised controlled trials (RCT) in relation to a certain area of interest. Currently, in the context of healthcare interventions also clinical controlled trials (CCT) may be included.

Why RCT or CCT studies? RCT and CCT are commonly regarded as the most reliable research designs. Due to the design properties they allow for statistical comparisons between studies, with the influence of bias kept at a minimum. The results of separate research study outcomes can be analysed to one overall outcome measure indicating the overall effectiveness of a certain type of treatment.

<table>
<thead>
<tr>
<th>RANDOMISED CONTROLLED TRIAL</th>
<th>CLINICAL CONTROLLED TRIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Two or more interventions are compared in terms of effectiveness. One is the treatment intervention which is compared to an alternative form of treatment, no treatment or placebo</td>
<td>• Two or more interventions are compared in terms of effectiveness. One is the treatment intervention which is compared to an alternative treatment, no treatment or placebo</td>
</tr>
<tr>
<td>• Adequate method of randomisation: patients are assigned in random order to one of the interventions</td>
<td>• No method of randomisation: random assignment of patients is often not possible in or across healthcare settings.</td>
</tr>
</tbody>
</table>
since 1993, the Cochrane collaboration has been started as an international non-profit organisation which prepares, maintains and promotes the accessibility of systematic reviews. By now the number of Cochrane Centres is rapidly increasing throughout the world, like an epidemic. The scientific literature is generally dominated by American and European research. With the start of non-western Cochrane associations, also research studies conducted for instance on the African continent, may become more easily accessible.

All the reviews that are conducted worldwide are accessible through the internet via the Cochrane library, for instance on www.cochrane.de. In any good medical library you may find access to the Cochrane databases. You might also want to search the internet to see if there are any free trials through which you can search the Cochrane Library. Several databases are included in The Cochrane Library. One of them, The Cochrane Database of Systematic Reviews, contains Cochrane reviews and another, The Cochrane Controlled Trials Register, is a bibliographic database of controlled trials. The Database of Abstracts of Reviews of Effectiveness (DARE) includes structured abstracts of systematic reviews which have
been critically appraised by reviewers at the NHS Centre for Reviews and Dissemination in York (UK) and by other people, e.g. from the American College of Physicians' Journal Club and the journal Evidence-Based Medicine. The Cochrane Methodology Register is a bibliography of articles on the science of research synthesis. Also included in The Cochrane Library is a Reviewers’ Handbook on the science of reviewing research; a Glossary of methodological terms and Cochrane jargon; and contact details for review groups and other groupings in the Cochrane Collaboration.

But why should I search for systematic reviews in the Cochrane library, you might ask. When you have a patient with Alzheimer’s disease for example, you can search what are current insights of best practice medicine with this client group. Regretfully, that are not many music therapy reviews available yet, but also the information of other reviews might be helpful in developing your treatment goals, as later in the paper will be described.

As there are clear guidelines, which have been developed over the years by the Cochrane Collaboration about combining and evaluating research, the advantages over the Cochrane review are clear. The process is transparent, controllable and replicable. The Cochrane review is a scientific based instead of a subjective summary of the literature and the reviews are easily retrievable through the Internet. The reviews are written comprehensively and music therapists do not have to have the skills and the time to digest all the research studies themselves.

WHAT THEN IS A SYSTEMATIC REVIEW?

A systematic review is a review that strives comprehensively to identify and synthesise all the literature on a given topic. The Cochrane review is a systematic review with includes the procedure of meta-analysis. Meta-analysis is a statistical technique for assembling the results of several
studies in a review into a single numerical estimate. Many reviews are not systematic but are still valuable and helpful as long as the reader is aware of the procedure. However, a meta-analysis that is not a systematic review is likely to be highly biased and should be used with extreme caution (Light, 2002). The Cochrane Collaboration focuses particularly on systematic reviews of randomised controlled trials (RCTs) because they are likely to provide more reliable information than other sources of evidence.

A systematic review following the Cochrane principles consists of the following steps:

- Formulating the problem or research question (PICO)
- A comprehensive literature search: locating and selecting studies - Objective inclusion criteria for retrieved studies - A critical appraisal of the methodological quality - Objective data-extraction by 2> reviewers - Meta-analysis
- Structured method of reporting the results
- Improving and updating the reviews

The starting point of the Cochrane review is a good research question, which is also known as ‘PICO’. A certain client population (P) follows a certain type of treatment (I) which is compared to an alternative form of treatment (C) which results in a treatment outcome (O). An example of the PICO-question translated to music therapy is for instance: Do demented elderly (P) benefit more from music therapy (I) than from comparative treatment modalities (C) in reducing problems in the cognitive, social, emotional and behavioural domain (O)? After formulating the research question, the following step is a comprehensive literature search to find all the relevant literature that may be included in the review. Recommended sources for literature searches are Medline, Embase, PsychIndex etc, which all can be found on the Internet. A clinical librarian can assist in formulating the right search-strategy. A comprehensive, unbi-
ased search is one of the key differences between a systematic review and a traditional review. While electronic databases such as Medline are powerful tools for locating studies, only 30 - 80% of all known published randomized controlled trials are identifiable using Medline (Clarke et al., 2001). Databases such as Medline do not include all available music therapy references. It is advisable to search also for music therapy literature in specific databases such as made available through the University of Witten-Herdecke on www.musictherapyworld.net or to conduct hand-searches.

There are many helpful tools available by which you can manage the retrieved references such as ENDNOTE or REFERENCE MANAGER. Through these programmes you can access for instance the Medline database and you can import the retrieved references directly into Endnote or Reference Manager.

FIGURE 2.

<table>
<thead>
<tr>
<th>Levels of evidence</th>
<th>1a</th>
<th>Systematic review based on RCT’s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1b</td>
<td>Randomised controlled trial (RCT)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Controlled clinical trial (CCT)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Patient series with control condition</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Patient series without controls</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Case studies</td>
</tr>
<tr>
<td></td>
<td>**</td>
<td>Expert opinions</td>
</tr>
<tr>
<td></td>
<td>**</td>
<td>Qualitative research</td>
</tr>
</tbody>
</table>

See also: http://cebmjr2.ox.ac.uk/docs/levels.html

After finding references and ordering the hard copy’s, then the next step in the Cochrane review is selecting the best and excluding the worst designs. Not every retrieved study is included in the Cochrane review.
Only RCT’s or CCT’s are allowed to be included, in order to conduct a proper analysis. In general, the following order is used to evaluate research. The highest level of evidence is derived from a systematic review that is based on RCT’s, followed by RCT or CCT studies. Generally excluded in the Cochrane review are the patient-series with or without controls and case studies. The lowest level of evidence is formed by expert opinions. Qualitative research is generally also excluded in the Cochrane review. At the moment a Qualitative research group has been started at the Cochrane Collaboration that is looking at the merits of qualitative research. In current music therapy research patient series, case studies and qualitative research dominate. Relatively little systematic researches have been conducted.

In the table on the left, evidence from step 1 is the strongest and from Expert Opinions the weakest. The strength of evidence is related to the degree to which bias and confounding factors are controlled for. By definition this means that quantitative study designs provide the strongest evidence because they provide the best means of controlling for bias, but only if the sample size is large enough and appropriate to control for random effects. This does not mean that weaker types of evidence are not reliable, but simply that it is more difficult to control for bias. Studies that show dramatic effects require less control for bias than those which only show small effects (Light, 2002).
For the Cochrane review on dementia we have retrieved a total of 354 references. Most of them were descriptive or anecdotal reports concerning the topic of music therapy and dementia. After excluding these references, a total of 102 remained which were possible research studies. Of those titles, we ordered all the hardcopies and examined if they were suitable studies to be included in the review. As we can see from the graph, about 90% of the retrieved studies consisted of case studies and patient-series designs which were excluded from the review. A total of 10 studies was adequate for inclusion. The last step of the Cochrane review is the ‘meta-analysis’: the combination of the results of separate, comparable studies to an overall measure, indicative for an overall conclusion about the treatment effectiveness. The Cochrane Collaboration has developed a special program for this purpose: RevMan 4. All data that has been gathered is presented in the Cochrane review and can be checked on the Internet. All the included reviews in the Cochrane Library are written following the same standard.

- a 'cover sheet', a structured abstract
• a structured report of the review: objectives; methods; the results and
discussion of the results of the analysis, list of excluded studies judgments about the implications for practice and research
• tables of the characteristics of the studies included in the review,
including information relevant to an assessment of the methodological quality of each of the studies included tables and graphs of the results of the review, with presentation of the statistical syntheses (meta-analyses)

To summarize, in this section of the paper has been described what a systematic review is. The purpose has been to demonstrate how (Cochrane) reviews are written and according to which standards, in order to understand them more thoroughly. In the next section of this paper will be discussed how they can be implemented in music therapy practice.

Edwards (2002) points out that it has been useful to outline the position of music therapy in relation to the Cochrane library when discussing music therapy employment proposals in medical contexts. In time, we will have more reviews which will also include music therapy interventions. At the time of writing, two Cochrane reviews are in process which concern the effects of music therapy. The dementia review as described before and Anna Marathos Tooth and Christian Gold work on a review about music therapy and depression (see reference section). The Universities of Witten-Herdecke, Aalborg and Melbourne are also writing systematic reviews about the effect of music therapy with a variety of client populations. At the time of writing, luckily these reviews are all written by skilled researchers.

The popularity of Evidence Based Medicine has become immense. This may also have it pitfalls as the term already has been misused on numerous occasions, which in time may lead to Evidence Biased Medicine. Edwards (2002) describes aptly that music therapists need to continue to discuss and debate their view as what constitutes knowledge, expertise
and ‘evidence’ in our profession. But the question is to what endresult will this discussion lead. Do we continue on our own and advocate music therapy effectiveness within our own ‘church’ and will we be establishing guidelines on our own of what ‘evidence’ is? Or will we be able to bring some of our knowledge across? Some authors have underlined that a RCT is not a suitable design to adequately describe music therapy’s process for all sorts of arguments. We should both work on establishing evidence to ourselves and to others. This may take different strategies. For developing our own profession, study designs such as the qualitative design might enable us to gain more insight into its processes for our own professional development. On the other hand, we should not neglect the fact that we also should establish evidence to other professions. In terms of the current levels of evidence: music therapy does not do well in establishing a sound argument to others than ourselves. We should come up with evidence on all sorts of levels. We do well in terms of case studies and patient series but there are few randomised trials conducted in music therapy. Music therapy should also prove its value across people and across therapists in a randomised trial. In the Netherlands, multidisciplinary guidelines are being developed in which psychotherapeutic ‘evidence’ is given in line with evidence from other modalities such as music therapy. Not without reason, music therapy as an intervention in the treatment of depression has ended up at the last pages. Simply because we cannot come up with similar arguments of which I am sure that we are able to provide in time. Does it have to do with levels of evidence or with the current level of music therapy research? I do not know. Tony Wigram pointed out correctly that music therapists in their profession should not have to be researchers nor are they paid for it. We lack in general research studies, as is the case in the Netherlands where we do not have university support or adequate supervision for research in the field of music therapy. In the current line of reviewing evidence of conducted trials, we have to
conduct similar but different research strategies. Not only to conduct music therapy research in purpose to demonstrate effectiveness. I hope to read at some time about a study which did not work at all: this is also evidence which we should allow ourselves to happen to further music therapy development.

In the second part of this paper we will look at Evidence Based Music Therapy from the therapists’ point of view.

Evidence Based Practice

The phrase ‘Evidence Based’ first caught my attention in the beginning of the year 2000, in a medical bookstore. There I bought the book: ‘Evidence Based Medicine: How to practice and teach EBM’ by David Sackett and colleague. I read it and in the following weeks noticed the phrase ‘Evidence Based’ popping up in newspaper articles. These concerned changes in health care policy and demands from consumer organisations. The words were used in various contexts and seemed to have a lot of different meanings. Apart from misuse of the phrase ‘Evidence Based’ there are in fact several understandings of Evidence Based Practice (EBP). They can be summed up by three levels in which health care professionals practising EBP operate. (Mace et al., 2001)
At the first level ‘best evidence’ is used in making decisions in our everyday work. At the second level the five steps of Evidence Based Medicine are used to solve problems arising from everyday clinical work. These five steps are followed through even if no satisfying evidence is found to support them. At the third level EBP concerns the theories about what we do and what is effective. It stands a bit apart from everyday practice but has wide implications for our daily work. Writing Cochrane systematic reviews and conducting a controlled trial in the workplace are examples of EBP on this level.
As with all new ideas and practices that spread rapidly through health care world wide, the phrase ‘Evidence Based’ is and has been misused. Some policy makers for instance, use the words to propagate EBP as a form of health care in which only therapies of which the effect has been proven are funded. In this approach ‘effect’ reigns, and theory is ignored. The problem with this ‘effect-based’ medicine is that it assumes that diagnosis is equal to the patients problem for which he/she seeks help. In regular medical medicine this can be done with relatively little serious consequences. In psychological settings however, this approach has major negative consequences. This is because diagnostic classifications, as used in psychiatry, are still a set of hypotheses about what is wrong with clients. They have been formed to make it possible for clinicians and researchers to make diagnoses, communicate about them, treat the various psychological disturbances and to research them. (American Psychiatric Association, 1994) Thus they cannot be used to practice the cookbook medicine or ‘effect based’ medicine without losing its scientific basis.
On the other side of the spectrum we find the ‘all evidence included based practice’. In this approach individual health care workers or their professional organisations do not distinguish qualitative research (patient series and case studies) from quantitative research. It will not be surprising that this approach is often used by individuals that want to meet the demand for evidence, but worry about the amount of good conducted controlled trials in their area of specialisation. The problem here is obvious; it lacks the scientific standard that is widely appreciated, and which enables communication with other disciplines.

EBP is in essence a sincere effort to combine the best scientific evidence according to scientific standards with the best patient–centered care. This is the EBM Sackett and colleagues introduced, and that is advocated by the Cochrane Collaboration, as pointed out in the first part of this paper.

The definition of Evidence Based Music Therapy is:

Combining the best available scientific evidence with the clinical expertise of the therapist and client values and wishes in the treatment of clients.
Similar to the steps in writing a systematic review the five steps of EBMT are:

1. formulating an answerable question (using the PICO-elements)
2. searching for evidence (in this paper the evidence will come only from Cochrane Systematic Review)
3. critically appraising the evidence
4. application of the evidence to your patient
5. evaluation of the previous steps

I will demonstrate what EBMT looks like by introducing an example from my own clinical work as a music therapist in a day-care clinic for adult psychiatric patients.

John, a 20-year-old man suffering from psychotic episodes was taking part in a Psychotic Vulnerability Training program for young adults with schizophrenia related conditions. He was not responding well to the treatment, had difficulties in making contact and showed signs of depression. One session the patients played different parts of a round, Father Jacob, on different instruments, and by focusing attention entirely on each part, the song sounded right. John turned to me at the end of the session with delight and said: “this really works for me, by concentrating
entirely on my part I get grip on myself. That is something I miss most of the time”. Intrigued by his comment, I wondered if there existed a Cochrane Review on the subject of attention training and its benefits for patients with schizophrenia related conditions. If so, maybe the intervention should be included in the sessions for all the patients of the Psychotic Vulnerability Training. I went about it in an evidence based way. I formulated a question:

As you can see, all the PICO-elements are there, patient, intervention, comparison and outcome. Then I searched for evidence and turned to the Cochrane Library. With the search phrases ‘ music, concentration, schizophrenia’ there were no results. I restricted the search to the phrase: schizophrenia. About 150 references were retrieved, most of which were on pharmacological treatments. I luckily had the time to go through the remaining abstracts, and found one on ‘ Cognitive Rehabilitation for people with schizophrenia and related conditions’. The reviewers conclusion was that cognitive rehabilitation, when used, should be presented to the client as ‘ experimental in nature’, because no evidence was found that
cognitive rehabilitation improved cognitive skills in psychotic patients. The cognitive rehabilitation consisted of attention training on a computer.

So I had my evidence, trusted its quality (because the review has been accepted for the Cochrane library) and thus could skip step 3: critically appraising the evidence.

Moving on to step 4 had to see if the evidence could be applied on my patient. The following questions and notes arose:

- Are there reasons to believe the intervention would not work with our patient (-group)?
- Age, culture, sex, geographical origin are levelled out in Cochrane systematic reviews
- Comorbidity has to be considered!
- Qualitative research can play an important role in determining how to apply the evidence
- Do I possess the expertise? What are the costs?
- What are the wishes of my patient?

To apply the evidence to John's case we take a look at the inclusion criteria for the review, costs, expertise needed and patient wishes. Would John have been accepted for the experimental group? Does he have the same age, does he have any additional diagnoses? Does he come from the same cultural background? If not, do I have a reason to believe the different cultural background would not make the intervention described work? Does a different sex play a role?

Qualitative research can supply answers to the question: are there reasons to believe the intervention would not work with our client? Cochrane has a group focussed on the application and standardisation of qualitative research.

Note: In this case I did not have access to evidence from a review on music therapy and schizophrenia. In future, this will hopefully change, as
more music therapists are starting to write Cochrane Reviews. At the moment Cochrane Reviews on Music Therapy are being prepared, for instance Kristian Gold and Anne Marathos Tooth’s protocol on MT and depression.

Carrying on with step 4 in the case of John, two problems in applying the evidence from the review appeared:

When used as attention training, the music therapeutical intervention of playing a round contains similarities to the attention training on the computer, because of its similar goal.

Following the reviewers conclusion, I concluded that it would be unethical to present the exercise done in the MT session as beneficial for John’s cognitive skills. John himself seemed to hold the experience of getting a grip on himself as the most important aspect of the intervention. It seemed I could not offer him an evidence based intervention which would help him get a grip on himself. Instead I decided to pay more attention to his fear of disintegrating and mourning over his illness.
Summed up in the slide are the consequences for the treatment of John from the evidence I found:

**FIGURE 9.**

- No psycho-educational explanation or encouragement was given to John about exercising his concentration by playing music.
- He was encouraged to enjoy himself in his own way.
- Special attention was given to his fear of ‘losing track’ of himself.

In step 5 steps 1–4 are evaluated. I decided to include special attention for mourning for all patients in the ‘Training Psychotic Vulnerability’.

Other examples of evaluations in step 5 are:

- working on your internet skills
- getting access to the Cochrane Library
- ordering a new drumset for aggression-regulation training

As we come to the end of this presentation we will sum up the characteristics of Evidence Based Music Therapy in this slide:
Summing up:
What is Evidence Based Music Therapy?

- The application of EBM on music therapy
- Applying the five steps on everyday MT questions
- The more best evidence the more useful the intervention/method
- Contribution to existing MT theories/methods
- A change in language: it might work does not mean it doesn’t work
- Provides a common language to communicate with colleagues

To summarize, in this paper we have described the possible benefits of evidence based working in music therapy.

We hope more music therapists will participate in the writing of Cochrane Reviews on Music Therapy or will find assistance in their work by using systematic reviews as an easy accessible source of information to retrieve current insights in research.

Usefull websites:
www.cochrane.org
www.cochrane.de
www.ebmt.info

References:


**Contact**

**Annemiek Vink** is a psychologist and a music therapy teacher at the Conservatory in Enschede (Saxion Hogeschool Enschede), The Netherlands. She is working on a PhD-research studying the effect of music therapy in reducing agitation in demented elderly. She is a board member of the Dutch Music Therapy Foundation (Stichting Muziektherapie).

(First part of the paper)

e-mail: [a.c.vink@planet.nl](mailto:a.c.vink@planet.nl)

website: [www.knoware.nl/users/jdehaas](http://www.knoware.nl/users/jdehaas)

[www.stichtingmuziektherapie.nl](http://www.stichtingmuziektherapie.nl)

**Manon Bruinsma** graduated as a music therapist from the Conservatory in Enschede (Saxion Hogeschool Enschede), The Netherlands. She works as a music therapist in a psychiatric facility in the Netherlands and has introduced the idea of Evidenced Based Music Therapy in the Netherlands. (Second part of paper)

e-mail: [msbruinsma@gmx.net](mailto:msbruinsma@gmx.net)

website: [www.ebmt.info](http://www.ebmt.info)

Clinical practice is a messy laboratory and the purity of academia is often polluted by day to day realities. This is not to say that I am against controlled clinical trials nor evidence-based medicine. Indeed, throughout the last two decades I have written expressly that medical practitioners and music therapists need to be reflect on their own practice through research and share that with others – that is, to become reflective practitioners in a community of inquiry (Aldridge 1996). Controlled trials are one of the research methods that we have in the toolbox of research. There are many valid methods; finding the appropriate method to answer the question that we are asking is the central issue. To force all questions into one method is methodolatry, not methodology. Unfortunately, we have the same problem today with the concept of evidence-based medicine. The concept is sound when it stays within its own borders. When randomised controlled trials become the only evidentiary basis for health care delivery then we have a triumph of a scientific technocracy that ignores the caring and social dimension of health care delivery. This is
particularly exacerbated when inexperienced practitioners, often with no
direct experience of therapy, and sometimes with a very limited back-
ground of research experience, begin to suggest to others that they are not
doing their job properly or how they could be doing their job better from
a highly restricted set of research evidence.

I was in a conference a few years back in Ferrara, Italy when a leading
music therapy researcher began to explain to me how best melody could
be understood. More than that, the researcher began to explain how I
should best understand melody to make my work appropriate. When I
asked the researcher ‘What do you experience when you play a mel-
dody?’, he had no answer. Not being a musician, he had no experience to
fall back on. Yet, he assumed that by being an eminent researcher he
could tell me how best to do research into ‘melody’, when a vital aspect
of understanding was missing. We seem to be experiencing the same in
music therapy practice. Some “experts” are advising practitioners with-
out adding the rider that they are speaking from a limited practice experi-
ence or from a limited research experience. A research elite, with limited
practice and experience, are trying to assume the mantle of advisers by
adopting a set of rules from an essentially bureaucratic culture of medical
hegemony.

The delivery of health care is still a contentious issue. The initial assump-
tions by Beveridge were that the cost of the National Health Service in
Britain would fall as therapy brought about reductions in illness. Instead
we have a spectrum of redefined health needs that have continually
expanded. Health care needs are increasingly medicalized and self-care is
becoming a lost cause abandoned to a consumer culture of medical ser-
sices. What were once called alternative and complementary approaches
have been commodified as modern health care. Rules governing guide-
lines for the application of the medical product, misguidedly called a ser-
vice, is controlled by the recommendations of an increasing medical elite, the purveyors of evidence-based medicine. These guardians of the medical scientific culture have undertaken to engineer the delivery of health care based on a set of rules that are far removed from the everyday practice of clinical medicine, health care delivery and certainly music therapy practice. Evidence-based medicine can tell us little about suffering and dying, nor about healing, and nothing about caring. Neither does it celebrate those artisans of clinical practice, music therapists, where tradition and expertise are the daily tools of the trade. Expertise is not evidence but in the healing relationship it is paramount.

Medical bureaucracy is establishing an orthodoxy that is impoverishing our healing cultures. By denying recognition of a variety of evidences for healing, then we are denying our communities the right understand their own healing resources and express their own needs. We may have a statistical basis for successful treatment but suffering will continue.

We need an approach to music therapy research that stays close to the practice of the individual clinician; that is, the musician as therapist. Each therapeutic situation is seemingly unique. Yet, we compare our cases and share our knowledge with each other. Research methods are means for formalising our knowledge so that we can compare what we do.

What I argue for is a flexible structure that can be applied to clinical practice (see ‘Case studies in music therapy research” Jessica Kingsley Publishers: London, forthcoming). The practice is allowed to remain true to itself, although any research endeavour, by the nature of its reflexivity scrutiny, alters practice. In doing research we ask questions of ourselves as clinicians, and when we involve our patients in the process, then they too will reflect about what is going on.
Therapy, treatment or care?

There is a tension inherent within music therapy research. It is music research, an aesthetic activity contextualised by a therapeutic situation. We can utilise a broad spectrum of musicological approaches. It is also a therapy research, albeit defined by its emphasis on music, and therefore subject to forms of therapeutic scrutiny. When we attempt to enter systems of health care delivery, then we must be aware of the conventions of legitimate research. But, those conventions are not fixed. We can demand that they accommodate what we have to say if we argue our point articulately and rigorously, just as we must be prepared to offer appropriate research related to those conventions. Case study designs offer such formats. The task that we have before us is to explicate and negotiate those flexible conventions.

ADVOCACY AND THE EVIDENCE-BASED METAPHOR

The evidence–based medicine debate places case reports as ‘mere opinion’ along with recommendations from expert committees (Sackett, Rosenberg, and Haynes 1996). Yet opinion is the common currency of our daily lives. Opinion is informed and that is what patients and colleagues expect from us. One of the sources of that opinion will be clinical trials but these are only one of the possible sources. The danger of an evidence-based approach is that evidence is restricted, and one of those restrictions is an elite opinion based upon a certain set of defined criteria. Hence my plea for pluralism.

Yet, the concept of evidence is being used here as a legalistic metaphor rather than a scientific metaphor. In a courtroom, various forms of evidence will be produced where experts are invited as witnesses. It makes no sense in restricting the range of evidence. We do have to establish the reliability of the witnesses and the basis of their expertise but not restrict the forms of evidence a priori. I am not advocating the use of dogma, nor
opinions without reasoning, simply that there are various forms of reasoning. Case studies offer reasoning through perspectival forms as research practice conventions. Common to these forms is a focus on a specific theme, locating the evidence within bounded contexts, establishing the sources of the demonstrative material that we are using and arguing our conclusions only from the material that we have presented. This is simply sound research methodology, no matter from what methodological persuasion we come. The demonstrative evidence may be measurements, or it may be recordings, it may be interviews, or it may be questionnaires.

Whether or not we accept the validity of the witness is a political act. In the music therapy research debate we are arguing for wider inclusion in the service delivery of health care. Evidentiary material must have a broad base, if case studies are being refused under the guise of appropriate research then this has to be recognised as simple prejudice by those who determine what is “appropriate”. The basis of many therapies is, in reality, “case” based.

There has been a shift of interest in the concept of disability from an emphasis on biological impairment to the unique experiences of the sufferers. Similarly, we may argue that relevant outcomes are dependent upon what the sufferer has to say. Practitioners also relate outcomes in terms of a clinical narrative and both clinicians and patients have global vocabularies regarding functioning and coping (Bilsbury and Richman 2002). While evidence-based medicine emphasises quantification, it runs the risk of loosing the vital elements of individual difference in particular contexts, which is what we see as clinicians. Change is the experience of qualities relating to stages of transition rather than being a sequence of symptom scores. Case studies allow for us to include transitions as process and as events, as the important moments between the scores.
The greatest challenge of “evidence” is how such evidence finds meaning in everyday practice. While we talk of music therapy, the actual practice is varied across a broad spectrum of practices and these themselves may vary across continents according to which model is being used. In psychotherapy research there has been an attempt to standardise treatment by offering treatment manuals for empirically validated treatments for specific client groups and particular problems (Beutler, Moleiro, and Talebi 2002). The primary reason being to provide insurance administrators with selection criteria in choosing which services to provide.

In contrast, there is research demonstrating that it is common, global qualities related to expectation about treatment, the perceived charisma of the therapist and the relationship between therapist and client that are effective (Luborsky, Singer, and Luborsky 1975).

A difficulty of evidence based medicine, when it sponsors a treatment manual approach, is that the therapist is forced to follow a rigid treatment plan and those elements of spontaneity and creativity, that music therapy cherishes, are discarded. Furthermore, manual-based treatment will be based on treatments that are easily converted into manuals and these will tend to be both highly structured and short-term. This poses a skewed research cycle biased in favour of short term, highly structured interventions, that promote more research studies because they are easier to organise as clinical trials and are of short duration. We are still left with the problem of converting these studies into clinical utility. Nurses have also found the same problem in that “best practice” requires not only comparable outcomes from evidence based research but a knowledge of the context of service delivery that includes the patient and her community (Driever 2002).
What we need to debate is the nature of therapy as treatment or care. If we claim that music therapy is a form of treatment, then we fall under the rules of evidence for establishing the efficacy of treatment. If however, therapy is a form of care, then the rules change, and we can speak more openly of qualities of care. Music therapy is an overarching term for a variety of practices in a plethora of clinical, educational and social fields. This makes it difficult to provide any definitive statements about “music therapy”. We can take heart, however, as we only have to hear surgeons talking about psychiatrists to know that “clinical medicine” is also a craft of diverse practices.

If an aim of health care initiatives is to improve service then we can learn from industry. Quality is improved by attending to the process of delivery where suppliers are in a close dialogue with consumers. This also reduces costs. Any new attempts to collect information must begin at this primary care interface between the practitioner and the patient, and the practitioner and his or her sources for referral. This would mean an emphasis on local networks according to local need (Aldridge 1990) not bureaucracies of the faux elite with neither mandate nor experience.

However, we must first understand the complex process of health production before we can try to improve it, particularly in the field of chronic illness where many of us work. An understanding of health production must also be supplemented with measurement tools which represent the values of the producers at the work-face (practitioners), and the consumers with whom they meet (patients). Epidemiological methods can be developed to establish baselines from which the success of health care initiatives can be measured and outcomes can be monitored. One of the bases of epidemiology is the case study. From here we have our starting point. It is imperative that we develop a common language for health outcomes that is understood by the consumers (patients), deliverers
(practitioners) and providers (those who pay). This language is not to be dominated by a research autocracy. When we speak of health care we are not only concerned with economic aspects of health, but the practice of 'caring'. It is this qualitative demand which articulates the health care debate and stimulates the inclusion of music therapy into health care delivery.

Meeting health care, educational and social needs is a matter of social strategy and political will. Health is not an homogenous concept, it is differentially understood. Educational and social needs are negotiated not written in tablets of stone. Music therapy like medicine is not an isolated discipline but an agglomeration of concepts taken from a variety of fields. These fields include the arts, the humanities and the sciences.

The social understandings of health and education and how to practice therapy are not fixed. Patients and health care professionals negotiate solutions to health care needs from an extensive cultural repertoire of possibilities. This repertoire is composed of understandings from Western medicine, but also from folk or traditional medicine and modern understandings of psychotherapies and creative arts therapies.

Similarly, professionals working in educational and social care settings have varying agenda set within the communities in which they participate. These repertoires too are varied.

However, there are factors common to a variety of health and educational understandings. These understandings include promotion and prevention, health maintenance and indications for treatment. Such factors are influenced by economic strategies and cannot be divorced from considerations of community welfare. Poor housing and poverty mock any talk of music therapy initiatives based on consumer demand. There has to be a
minimum level of income whereby people are fed and housed before the luxury of health or educational choice can be exercised.

The future delivery of health care will depend upon accurate information about the management of resources. To assess health care we will need accurate and appropriate tools of assessment. Case studies, in their traditional role of advocacy, play an important role in establishing practice models. We can use tools of assessment that relate to the management of resources while remaining true to the people we are trying to represent.

**Music and therapy**

Research from a therapeutic perspective is not medical science in that it has no generalisable reference. The importance of such work is in its particular subjective and unconventional reference. While the aesthetic may appear to occupy a pole opposite to the scientific, I propose that a pluralist stance is necessary to express the life of human beings (Aldridge 2000). Pluralism is being used here in the sense that no political, ideological, cultural or ethnic group is allowed to dominate the discussion. That is why the evidence-based medicine needs a counter balance, not against the concept but to counter the idea that such a perspective is the only legitimate perspective to inform practice delivery.

Emphasising one authoritative base for music therapy research is suspicious. The quest for one superior model for empirical evaluation is the quest for disciplinary power and an attempt to marginalise other opinions. We have differing ways of languaging music therapy, as we have of musicking, but we can still respond to each other and find commonalities of understanding. These will be local rather than global. The concept of pluralism is borrowed from theology. The basis of the understanding is
that no one of us as human beings can begin to claim a full understanding of the divine, thus in all modesty we have to recognise that we have only parts of the picture. Surely the same goes for music therapy, no one group can claim hegemony, nor absolute understanding of the truth of what music therapy is. A challenge is for us all to come together and merge those various understandings. To do that we tell our varying stories in differing ways, all of which have their own validity. Whether they have a validity outside our own field of expertise depends upon how we negotiate that validity and which languages we encourage. One of these languages will surely be research and amongst its dialects will be those of case studies, amongst clinical trials and a rich variety of other methodological approaches.

What we need in clinical research is to facilitate the emergence of a discipline that seeks to discover what media are available for expressing this ecology of ideas which we see as a person, and with which we engage as a therapist or researcher to discern the meaning of change. These media may be as much artistic as they are scientific.

To work in this way is also to consider aesthetics; the essentials of pattern and form. For a research methodology in music therapy we cannot always revert to the questionnaire and a standard test. What we are challenged to develop is a way of presenting the work of art itself as it appears in the context of therapy. This is not to deny the value of the questionnaire and the standard test but to encourage an extension of our research repertoire to include other forms of assessment and presentation.
References


Growing Roots: Music Therapy in Neurosurgical Rehabilitation

Simon Gilbertson

Abstract

The field of neuro-rehabilitation is diverse and the settings in which these people are offered therapy are highly varied. Whether our clients have experienced changes to the brain as a result of traumatic damage due to violence or traffic incident, degenerative neurological disease, biochemical imbalance, vascular insults or tumor growth, there is a large body of knowledge about psychological and physiological processes that should be used to deepen our understanding of the clients’ situation and the context and indication for music therapy. If, we as music therapists, develop specific interventions for music in therapy that can assist people to arise to and surmount the challenges of neurological disorder then we must increase the level of awareness of these interventions within our own profession and within the medical world. Furthermore we must develop continuing education for therapists so that a professional level of proficiency in applying these techniques can be achieved.
Introduction

In April 2002, I began working as a research assistant at the Chair for Qualitative Research in Medicine held by Professor David Aldridge on a Structured Review Project at the Institute for Music Therapy, University Witten Herdecke, Germany. For the eight years before this, I was employed as Head of Music Therapy Department in the Klinik Holthausen, a clinic for early neurosurgical rehabilitation. The clinic provides rehabilitation for 210 adults and 60 children following neurosurgical treatment. Before moving to Germany from England in 1994, I worked as music therapist with children and adolescents in the Nordoff-Robbins Centre, London, with children and adults in the residential village ‘Ravenswood’ in Berkshire, and was the first therapist of the Open Door music therapy organization founded by parents of pre-school children in Chelmsford, Essex.

Overview

The field of neuro-rehabilitation is diverse and the settings in which these people are offered therapy are highly varied. Whether our clients have experienced changes to the brain as a result of traumatic damage due to violence or traffic incident, degenerative neurological disease, biochemical imbalance, vascular insults or tumor growth, there is a large body of knowledge about psychological and physiological processes that should be used to deepen our understanding of the clients’ situation and the context and indication for music therapy.

The first section of this presentation will focus on basic neuroscience relevant to music therapy in rehabilitation. Common trends in therapy methods found in neuro-rehabilitation will be discussed alongside the need for continuing education. This need should not be understood as something
that someone 'out there' should fulfill, but as a suggestion that it is our own responsibility as therapists to share our experience and expertise with each other.

In the second part, I will share with you some of the types of resources I consider useful for ‘neuro-therapists’ and will share some basic information about neuroscience and neuroscience research relevant to music therapy.

I will then go on to discuss an example in which basic neuroscience has assisted me in the past as a clinician in the past.

Finally, I will talk about our Structured Review Project at the Chair for Qualitative Research in Medicine, Institute of Music Therapy, University of Witten Herdecke.

**PART 1**

The slightest change in the brain can lead to immense changes in life.

The main areas of the brain are the brain stem, cerebral hemispheres, basal ganglia and the cerebellum. Within these areas, there are smaller regions that have specific functions. Disturbances of these regions cause specific function disorders. Though common function disorders seem very similar, the primary causes can be diverse. Therefore, the underlying disturbance can only to be diagnosed through the identification of a symptom complex.

**FIGURE 1. The main areas of the brain: brain stem, cerebellum and the four lobes of the cerebral hemisphere: frontal lobe,**
The cerebral hemispheres process thought, memory, emotion, language and physical movement. The cerebral hemispheres also have specializations in processing sensory information about images, sound, touch and pain. Changes in the cerebral hemispheres can lead to speech disorders such as the various forms of aphasia, memory disorders, movement disorders such as ataxia, a disturbance in the planning of movement, or a hemiparesis or paraparesis. A hemiparesis is a partial or mild paralysis of one side of the body and the term paraparesis refers to a paralysis of either the upper or lower extremities. If all four extremities are affected the term tetra-paresis is used. Changes in personality, orientation to person and time, mood and drive can be affected by dysfunction of the cerebral function.
The cerebellum controls the movement of our muscles. Dysfunction of the cerebellum causes disorders in the quality of our movements, negatively affecting velocity, direction and the balance of muscle tone between the antagonistic muscle groups involved in any movement. Some people may lose the ability to walk or to coordinate movements of arms and legs and other movements such speech, facial gesture or torso control if the cerebellum is affected.

-In the following video example to is possible to observe how the symptom ataxia, caused by damage to the cerebellum, makes it difficult for the patient to control his arm movements in drumming to a regular beat given by a metronome. This failing coordination of the antagonistic muscle groups in his arm leads to an over-extension movements in all directions. This dysfunction disturbs the patient’s ability to beat smoothly and in a controlled manner of expression.

FIGURE 2. Movie Ataxia
Amongst other functions, the brain stem is responsible for the regulation of our heartbeat and breathing. The brain stem is the main connecting pathway between our central nervous system and the peripheral nervous system spread throughout the rest of the body. Both receptive and command information is moves up and down the spinal cord entering the brain via the brain stem. Damage to the brain stem is always accompanied by severe functional disturbances and can be fatal.

The following table shows some further clinical symptoms and symptom complexes that may affect the lives of people after brain injury.

<table>
<thead>
<tr>
<th>Term</th>
<th>General description/category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnosia</td>
<td>Disturbance of memory processing</td>
</tr>
<tr>
<td>Aphasia</td>
<td>Speech/language disorder</td>
</tr>
<tr>
<td>Ataxia</td>
<td>Disorder of movement coordination</td>
</tr>
<tr>
<td>Coma</td>
<td>Severe awareness disorder</td>
</tr>
<tr>
<td>Dysphasia</td>
<td>Speech disorder</td>
</tr>
<tr>
<td>Dyspraxia</td>
<td>Disorder of movement</td>
</tr>
<tr>
<td>Effect disorder</td>
<td>Psychological disorder</td>
</tr>
<tr>
<td>Memory disorders</td>
<td>Neuropsychological function disorder</td>
</tr>
<tr>
<td>Neglect syndrome</td>
<td>A reduction of spatial perception of space and body</td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
</tr>
<tr>
<td>Persisting Vegetative State (PVS)</td>
<td>Severe awareness disorder</td>
</tr>
<tr>
<td>Personality changes</td>
<td>Psychological disorder</td>
</tr>
<tr>
<td>Post Traumatic Stress Syndrome</td>
<td>Neuropsychological disorder</td>
</tr>
<tr>
<td>Spasticity</td>
<td>Disorder in control of muscle tone</td>
</tr>
</tbody>
</table>

It is my belief that the orientation of a therapist can influence their need for specific knowledge and expertise, but the knowledge of basic neuroscience is an essential requirement for every therapist working alongside patients with neurological illness.
As trained therapists, we follow models of therapy that we have been taught. Clinical experience forms the way we choose and apply an intervention. Sometimes we may develop new ways in which we make use of music in, or as therapy.

There are notable trends in models of music therapy applied in the field of neurology.

One of these models focuses upon the facilitation and rehabilitation of function. The main areas focus upon motor rehabilitation and speech rehabilitation. Motor rehabilitation is based on the ‘rhythmic stimulation and rhythmic organisation of motor training’ (Thaut et al 2001, p.164). The use of music in the context of motor rehabilitation has been discussed increasingly during the past years (Burke 2000, Hummelsheim 1999, Prassas 1997) though the first mention of this use of music was in 1954 (Fields 1954). Interest in the relationship between music and speech function has been widely documented in the literature (Oppenheim 1888, Luria 1965, Yamadori, 1977). The application of music as/in therapy in neuro-rehabilitation has focussed upon rehabilitating speech ability (Albert 1973, Seki 1983, Sparks 1974). I am only aware of two published models of therapy with people with speech and language disorders that have appeared during the past twenty years. In 2001, Kennelly, Hamilton and Cross (2001) published an inspiring article about the use of music therapy and speech pathology with children with acquired brain injury. The focus of the work is the rehabilitation of speech ability and language skills. This article is of particular importance as it deals with the specific nature of rehabilitation with young children. The children portrayed in the article are 3 years old and 12 years old. Monika Jungblut has been carrying out research in Germany into therapeutic uses of music in the
treatment of non-fluent aphasia in late rehabilitation. Preliminary results have shown such positive trends of change that challenge therapists to rethink preconceptions of the limited potential of late rehabilitation. Alongside offering yearly training seminars in Wrzburg Germany, Monika Jungblut has published a report of her work (Jungblut 1999). Her doctoral thesis will be completed in 2003.

The second of these trends in therapy focuses on treatment based on psychological models of intervention. Music is described as a path of communication that can be used to facilitate contact and therapeutic relationship to work with patients with a wide range of neurological disorders (Aldridge 1991, Brodsky 1986, Gadomski and Jochims 1986, Gustorff 1990, Jochims 1999 & 1990, Leischner 1991, Nayak et al 2000). These approaches have been used in developing therapy for a wide range of patients. The treatment of patients in coma, with aphasia, personality changes, organic brain syndrome, neuropsychological disorders, Alzheimer’s syndrome, multiple sclerosis, Parkinson’s disease and cancer is continuing to develop in many clinics throughout the world.

There are attempts to combine the understanding of functional and psychological processes and to convert this understanding into a neuro-behavioural framework of practice. Magee (1999) describes her understanding of such a framework, ‘I consider not only a person’s psychosocial needs but give an equal consideration to their neuro-cognitive functioning In doing so I gain an understanding of the meaning musical events hold for a person who is cognitively impaired and how his or her responses may best be interpreted’ (p.201).

There are many more forms of intervention in this field that I become aware of through exchange with colleagues, informal presentations of clinical work and case reports which are not found in the literature. This
creates a misleading impression of the application of music therapy offered to people living with the challenges of neurological disorders. The published literature presents an image of music therapy that either focuses exclusively upon motor and speech rehabilitation or psychological issues. Though some other approaches can be found (Knox 1996, Mariauzouls 1999, Gilbertson 2000, Tomaino 1998), the reports are limited in number. We must be careful not to fall into the trap of only being aware of widely published material. Clinicians who have developed a model of intervention should be encouraged to write and publish. This is important in order to maintain the wide spectrum of clinical applications of music therapy. Decision makers will look to the published literature for evidence for the necessity of therapy provision. Music therapy can be effective. Music therapy will not be seen to be effective if reports of the effectiveness are not published.

Whereby I have discussed the importance of student internships elsewhere (Gilbertson 2002) the culture of continuing education for therapists in ‘neuro’ should be developed. There is a very limited amount of training and education specifically relevant for therapists working in this area.

Pioneering clinicians have begun researching facets of music therapy in ‘neuro’ but most research activities into the basics of music and the brain are being carried out in fields outside of music therapy.

In a past search of MEDLINE via PubMed I searched for the five phrases shown in the table below. As these results only include articles in journals indexed by PubMed/MEDLINE and we know that the coverage of music therapy journals in this database is extremely limited, one can expect to
find more references to relevant articles by searching other databases or by asking colleagues.

<table>
<thead>
<tr>
<th>terms searched</th>
<th>number of references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aphasia and Music</td>
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</tr>
<tr>
<td>Brain and Music</td>
<td>599</td>
</tr>
<tr>
<td>Brain tumor and Music</td>
<td>21</td>
</tr>
<tr>
<td>Epilepsy and Music</td>
<td>93</td>
</tr>
<tr>
<td>Stroke and Music</td>
<td>49</td>
</tr>
</tbody>
</table>

Further sources of bibliographic information are stored in the database ‘MTDATA 4’ on the Info CDROM IV, and the newest ‘MTDATA 5’ database on the future CDROM V, produced by the University Witten Herdecke, and the Music Therapy ONLINE Database provided on the Internet at www.musictherapyworld.net. There are other databases providing bibliographic information but the aforementioned databases are a good starting point as they are specialised in music and music therapy literature.

*Which techniques are being used in neuroscience research?*

During the past decade the radiological techniques used to carry out neuroscience research have developed and the most widely used techniques are Magnetic Resonance Imaging (MRI) or Nuclear Magnetic Resonance imaging (NMR) and functional Magnetic Resonance Imaging (fMRI). The figure below shows an example of an image created with MRI. The patient experienced a severe ataxia caused by damage to the cerebellum. The position of damage can be seen in the white areas in the middle two images and the dark areas in the lower two images. I have mentioned the
The following image has been created using the Functional Magnetic Resonance Image technique. Neuronal firing literally burns up glucose
and oxygen and this method can show the areas in which the most oxygen is present. It can produce four images each second and thus can show processes of change in the brain. The example shows the areas as the test person is listening to music (blue) and looking at a picture (red).

**FIGURE 4.** Figure 4: Image of the brain created with fMRI

Similar to fMRI, Positron Emission Tomography shows which areas of the brain are working hard through their consumption of fuel. This process however needs the injection of a radioactive marker into the bloodstream.
The technique Near-Infra-red Spectoscopy (NIRS) is also based on displaying fuel consumption - in this case by measuring the varying amount of low-level light waves reflected from the brain.
The Electroencephalography (EEG) measures the electrical patterns caused by brain waves and has been widely used in early neuromusical research. Magnetoencephalography (MEG) also measures the brain waves, but measures the magnetic signal and not the electrical field. This method is still young but has great potential as it is faster and has a higher resolution in real time activities.

For an introduction into the application of the techniques in a research setting I can recommend the following article: Tervaniemi, M. and van Zuijen, T.L. Methodologies of Brain Research in Cognitive Musicology (1999) J New Music Research 28,3,200-208

**PART 3**

**CLINICAL EXAMPLE**  I would like to share with you some experimental work carried out during my time at the Klinik Holthausen, Hattingen, Germany.

The patient experienced a high-grade stenosis of the internal carotid artery right and intra-operative right-sided ischemia in the areas of the cerebri media and posterior artery. This means that the right carotid artery became severely restricted or blocked and made it impossible for blood to travel through the artery. If areas of the brain are not provided with enough oxygen irreversible cellular damage can occur. During neurosurgery the patient additionally experienced reduced blood flow within the right hemisphere. Reduced blood flow causes more severe damage than reduced oxygen supply. This is because blood flow not only is responsible for the transport of oxygen but also plays part in the control of the pH value and the homeostasis, or saturation, of cell matter.
In the following figure you can see the position of the internal carotid artery and the cerebri media artery in the brain.

**FIGURE 6. Artery system with cerebri media artery and internal carotid artery.**

One of the clinical symptoms this patient presented was unilateral visual neglect. This symptom is well known in the field of neuropsychology and has been studied for many years. The term describes a one-sided disturbance of visual recognition. The side of vision affected is contra-lateral, or opposite to the damaged side of the brain due to the crossed design of the brain. The right hemisphere is responsible for the left side of the body and sensory perception and vice versa. The following figure shows the loss of visual awareness in a patient with unilateral visual neglect that can be observed in picture reproductions made by a patient with unilateral...
visual neglect (taken from Kolb and Whishaw 1990). The effect of this disturbance become apparent through the omission of elements of the original pictures such as the numbers from 8 to 12 on the clock face and the left side of the house and the petals of the flower in the patients’ copy of the images.

FIGURE 7. Picture reproductions made by a patient with unilateral visual neglect (taken from Kolb and Wishaw 1990)

The next figure shows a symbolised image of the possible extent of visual perception of a person with unilateral visual neglect I experienced in therapy.
In reality the patient only perceives a segment of the right-hand side of his visual field. His power of sight is not affected and he has not become blind, but his central processing of visual material in his brain has been affected. The following photograph is an estimation of not only what the patient sees, but that he believes to exist in his real environment.
If the patients’ visual perception was affected in this manner, how is his spatial acoustic perception functioning? We know that the two systems work independently but ‘communicate’ with another in order to qualify and exchange information. If the patients’ spatial acoustic perception was intact then I contemplated whether the patient could make use of this ability to compensate and perhaps overcome his loss in spatial visual perception.
During early periods of rehabilitation I investigated the effects of three-dimensional hearing activities with this patient. I worked with the hypothesis that the ability to discriminate the origins of acoustic events can provide the patient with perceptive information alternative to his disturbed visual perception and through which he might regain perception of the failing left side of the surrounding environment.

In the first weeks it became clear that the patient could perceive sounds from his left ear through correctly naming the headphones from which the sound originated. This was astonishing as the patient reported not seeing anything on the left side and the complete left side of his body was paralysed.
I placed seven loudspeakers at a distance of one meter and in 30-degree steps from +90 degrees to 90 degrees around the patients’ head. I presented the patient with music, sinus tones and speech in a random order through the speakers three times each week. The following figure shows how I imagined the patient may experience the usual music therapy situation.

**FIGURE 11. Visual and acoustic perception of the music therapy situation by a patient with unilateral left-sided neglect**

During the following weeks the patient increasingly turned his head further towards the left side and was able to perceive and recognise the position of the source loudspeaker. Positive changes in his perceptive ability were registered by noting the relation between the source loudspeaker and the loudspeaker he pointed to. After c. 6 weeks, the patient identified 95% percent of the source loudspeakers correctly. It was possi-
ble for the patient to transfer the changes he experienced in the ‘experimental’ therapy situation and regained a wider range of spatial awareness literally opening his world of perception and experience.

The patients’ delight at rediscovering the left side of his environment, including the ability to recognise people, objects and spaces was immense.

I see the importance of this type of experimental work I have described here as twofold. It is possible to develop new independent therapeutic models and research areas. Secondly, this work can inform the interpretation of the patients’ behaviour in other settings such as music therapy, physiotherapy, in activities of daily life and in the home setting.

**PART 4**

**STRUCTURED REVIEW PROJECT**

I would like to introduce you to the Structured Review Project that is being carried out at the Institute for Music Therapy, University Witten Herdecke. The project team is lead by Professor David Aldridge and made up of Dr. Joerg Fachner, Martina Dembski, Markus Wentz, and myself.

**THERE ARE SIX MAJOR STEPS INVOLVED IN OUR STRUCTURED REVIEW PROJECT.**

In the first step we will be collecting every article that includes the term ‘music therapy’ or ‘music medicine’. We will complete this step by carrying out a systematic literature search and then retrieving the original articles. This involves searching for published and unpublished material. In the second step we will sort the articles into sub-categories based on area of inquiry and type of study (qualitative, quantitative, case study, case report). Thirdly we will assess the content of each of the articles...
using standardised rating tools. Where necessary we will develop the required rating tools.

The fourth step will be made up of meta-comparisons of related inquiries. In step five we will produce an overview of the literature.

In the final stage six we will aim to provide access of the results of database and overview to the profession.

Some relevant music therapy literature has not been published or is very difficult to retrieve. If you have any material that you think should be included in the study then please tell us about it either directly or by sending a note to my email address: simong@uni-wh.de

A last word

If, we as music therapists, develop specific interventions for music in therapy that can assist people to arise to and surmount the challenges of neurological disorder then we must increase the level of awareness of these interventions within our own profession and within the medical world. Furthermore we must develop continuing education for therapists so that a professional level of proficiency in applying these techniques can be achieved.

If you would like to enter into discussion, or initiate a forum about ‘neuro’ issues or other topics about clinical application, research or theoretical topics then please join us at the Discussion Board at www.music-therapyworld.net
References


Jochims, S. (1994) Establishing contact in the early stage of severe cranio-cerebral trauma: sound as the bridge to mute patients. Rehabilitation 33, 1, 8-13.


Author:

Simon Gilbertson

Research Assistant to

Prof. Dr. David Aldridge
Chair of Qualitative Research in Medicine

University Witten Herdecke
Alfred Herrhausen-Str. 20
D-58448 Germany
Tel.: +2302 926 769
simong@uni-wh.de

Auditive Stimulation
Therapy AST® as an intervention in subacute and chronic tinnitus.

Martin Kusatz *, Thomas Ostermann **, David Aldridge***

* Tinnitus Therapy Center (TTZ), Krefeld & Dusseldorf, Germany
** Department of Medical Theory and Complementary Medicine, Faculty of Medicine, University of Witten Herdecke
*** Chair of Qualitative Research in Medicine, Faculty of Medicine, University of Witten Herdecke

Abstract:

Background: Tinnitus is a noise, ringing, or roaring sound in the affected ear becoming a more and more serious problem for the health care systems. Integrative therapy concepts are regarded as a promising therapeutic concepts for managing tinnitus. The aim of this study is to present the results of the Auditive Stimulation Therapy AST®, a compact programme of music therapy originally employed in the treatment of chronic pain and developed specifically for tinnitus treatment. Material
and Methods: Data on out-patient-treatment results for 154 Tinnitus patients were collected and evaluated in a prospective observational study with three defined times of measurement (start, end and 6 months after the end of treatment). Apart from anamnestic data and subjective evaluation of treatment, the major outcome-parameter was the score of the Tinnitus questionnaire (German: TF). To evaluate effectiveness of the therapy effect-sizes according to Cohen were calculated.

Results: 51% of the patients were male. The mean value of patients age was 48.8 years (95% CI:[46.6;51.0]). 137 patients (89%) were capable of gainful employment which means they were in the age between 18 and 65 years. The duration of tinnitus was over 6 months for 80% of patients. 43.3% had been suffering from tinnitus for more than three years. In general, all subscales of the TF showed highly significant changes (t-test, p<0.01) between the measurement points “start of therapy” and “end of therapy”, while no significant differences were found between the measurement points “end of therapy” and “follow-up”. At follow-up, the values of the subscales are stabilized at a level recorded at the end of the therapy; a reduction to the level prior to treatment was not observed. The values for the effect sizes mostly ranged between medium (>0.5) and high sizes (>0.8). Closer investigations indicated that a combination of Music therapy and psychological training rendered the best effect-sizes.

Conclusion: This study demonstrates that music therapy is an effective treatment approach and offers a way to make progress in tinnitus treatment. Music has an aesthetic aspect, it is part of our cultural heritage. How we integrate sounds into our daily life, and how they become perceived as noise or music, is a complex activity involving the physiological, the psychological and the social. A therapeutic intervention that incorporates these understandings appears to offer considerable benefits, not as a cure but as a healthy adaptation.
**Introduction**

Tinnitus is derived from the Latin tinnire (ringing) and is defined as the perception of sound in the absence of any appropriate external stimulation. There is a basic difference between objective and subjective tinnitus. The term objective tinnitus is used for ear sounds based on genuine physical vibrations/ oscillations that may be perceived by others or even measured (Feldmann 1992). This type of tinnitus is rather rare. Subjective tinnitus is far more frequent. In these cases, only the person afflicted perceives the sounds. These may occur as rustling, whistling, whirring, ringing, or droning sounds. High frequency sounds are perceived far more often than low frequency sounds (Pilgramm et al. 1999), and a hearing impairment is detectable in over 50% of all cases.

The incidence of patients suffering from tinnitus in Germany and the western world is about 10%. About 1-2% of the population are severely disturbed by tinnitus and it may disrupt everyday activities and sleep (Rosanowski et al. 2001). If the symptoms continue for 6 months, then we consider the condition to be chronic, the degree of which differs considerably from person to person and afflicts patients in different ways (Kröner –Herwig 1997, Wilhelm et al 1995). A decompensated tinnitus is accompanied in most cases by other complaints, e.g. depression, anxiety, impaired sleep and concentration, sensitiveness to noises etc (Goebel et al. 1992; Goebel 1992); consequently, intervention is required. Several treatments of chronic tinnitus have been proposed and implemented (Kröner –Herwig 1997). Homeopathy and acupuncture are amongst the complementary therapies that are proposed (Park, White and Ernst 2000; Simpson, Donaldson and Davies 1998; Weihmayr 1998). Although there are several case-studies reporting efficiency of these treatments, the empirical support for therapeutic approaches like acupuncture in well-controlled studies is still weak (Biesinger 1999, Ernst 2000).
Today, integrative therapy concepts like cognitive-behavioural treatment compiled of counselling, relaxation therapy, music therapy and pharmacological preparations (lidocaine, neurotransmitters) are regarded as a promising therapeutic concepts for managing tinnitus. In particular, music therapy offers the chance of a global treatment approach for tinnitus patients (Neugebauer 1999). Harmony, for instance, as a connecting link between rhythm and melody has a social function. Rhythm may also influence biological parameters via tempo accentuation and metre (Mosonyi 1975). This is the theoretical background for Auditive Stimulation Therapy AST®, the music therapy programme evaluated in this paper (Kusatz 1991).

**Therapy**

Auditive Stimulation Therapy AST® is a compact programme of music therapy originally employed in the treatment of chronic pain and developed specifically for tinnitus treatment. It comprises a total of 10 therapy sessions and consists in specifically developed receptive music programmes in combination with an education programme. Musical Self Control (MSC) training is a music programme designed on the basis of music psychology and music therapy, the effectiveness of which was demonstrated in a clinical study (Kusatz 1991). The objective of MSC training ®, as a form of musical self control, is to improve patients’ control of ear sounds and to relieve their feelings of helplessness. Ringing in the ear, or strange sounds bring about alterations in perception. If we encourage the ability of selective hearing then we can promote some sounds in the hierarchy of perception, and to ignore other sounds or regulate them such that they are hardly perceptible. MW training ® improves, that is, lowers, the level of sensitivity to sounds.
In conclusion, the objective Auditive Stimulation Therapy is to improve a patient's emotional state and also to induce relaxation, to reduce anxiety and to stimulate changes in behaviour patterns that are unfavourable from the therapist's perspective. A particular focus is on perception of ear ringing which has to be controlled and influenced via music therapy intervention. The education programme is aimed at alterations on a cognitive level.

**Material and Methods**

At the Tinnitus Therapie Zentrum Krefeld (Germany), a research study was performed on a multimodal treatment concept (Krefelder Modell) in out-patient treatment of subacute and chronic tinnitus over a projected period of two years. Data on treatment results for 154 Tinnitus patients were collected and evaluated in a prospective observational study.

The out-patient therapy (duration: 2 weeks) comprised a total of 38 hours of therapy (20 h psychological training; 10 h music therapy – AST®; 8 h kinesitherapy) and also included counselling by ENT experts, orthopaedists and dentists. Data were collected with questionnaires immediately prior to and after therapy, with a follow-up after 6 months.

Apart from anamnestic data, the questionnaires also asked for a subjective evaluation of treatment. Especially, the Tinnitus questionnaire designed by Goebel & Hiller (2000), now the recommended standard tool throughout Germany, was employed at all times of measurement. Only those questionnaires were included, where more than 90% of the questions were filled out properly.

The main purpose of a follow-up interview of patients after six months was to indicate the degree of sustained therapy success. In addition, these
interviews provide important feedback for therapists and suggest longer-term positive treatment results, specifically in the areas of well-being and re-integration of patients in their family environment. Such a follow-up is of particular relevance in tinnitus treatment as the temporal dimension of the therapy success plays a major role here. We hear frequently that therapy success in most cases becomes evident over time. If a re-orientation in terms of perception takes place, then the consequences of this re-orientation, as therapeutic effects, are best seen in follow up assessments. For an evaluation of the efficiency and sustained success of the therapy, t-test was applied to show significant differences of tinnitus-questionnaire scales after therapy. To evaluate effectiveness of the therapy and to render the results comparable with each other and also with other treatment facilities in the health care sector, effect-sizes were calculated according to Cohen(1988) and corrected according to McGaw & Glass(1980).

**Results**

A total of N=155 patients were included in this evaluation. Sufficient follow-up documentation for assessment was available for n=111 patients (71.6%). Table 1 presents the basic socio-demographic and anamnestic data of patients.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>51.0%</td>
<td>49.0%</td>
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**TABLE 1. Socio-demographic and anamnestic data**

*Auditive Stimulation Therapy AST® as an intervention in subacute and chronic tinnitus.*
TABLE 1. Socio-demographic and anamnestic data

<table>
<thead>
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<th>Age Mean [95% Conf-Int.</th>
<th>Age Std.-Dev.</th>
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<td>49,3%</td>
</tr>
<tr>
<td>Secondary Modern School</td>
<td>25,0%</td>
<td>28,9%</td>
<td>27,0%</td>
</tr>
<tr>
<td>High-School/A-Levels</td>
<td>6,6%</td>
<td>18,4%</td>
<td>12,5%</td>
</tr>
<tr>
<td>University/College</td>
<td>13,2%</td>
<td>9,2%</td>
<td>11,2%</td>
</tr>
<tr>
<td>Profession</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work-men</td>
<td>32,9%</td>
<td>12,6%</td>
<td>23,1%</td>
</tr>
<tr>
<td>clerk</td>
<td>39,5%</td>
<td>47,9%</td>
<td>43,5%</td>
</tr>
<tr>
<td>Self-employed</td>
<td>3,9%</td>
<td>2,8%</td>
<td>3,4%</td>
</tr>
<tr>
<td>Not employed</td>
<td>23,7%</td>
<td>36,6%</td>
<td>29,9%</td>
</tr>
<tr>
<td>Duration of tinnitus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 6 month</td>
<td>19,7%</td>
<td>20,3%</td>
<td>20,0%</td>
</tr>
<tr>
<td>6-12 month</td>
<td>15,8%</td>
<td>16,2%</td>
<td>16,0%</td>
</tr>
<tr>
<td>1-3 years</td>
<td>19,7%</td>
<td>21,6%</td>
<td>20,7%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>14,5%</td>
<td>9,5%</td>
<td>12,0%</td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td>30,3%</td>
<td>32,4%</td>
<td>31,3%</td>
</tr>
<tr>
<td>Loudness of ear-ringing (from 0= „not at all“ to 10 = „maximum“)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean [95% Conf-Int.]</td>
<td>6,5 [6,0;7,0]</td>
<td>5,5 [4,9;6,1]</td>
<td>6,1 [5,7;6,5]</td>
</tr>
<tr>
<td>Std.-Dev.</td>
<td>2,2</td>
<td>2,8</td>
<td>2,5</td>
</tr>
<tr>
<td>Median</td>
<td>6</td>
<td>5,5</td>
<td>6</td>
</tr>
</tbody>
</table>
TABLE 1. Socio-demographic and anamnestic data

<table>
<thead>
<tr>
<th>Disruption due to ear-ringing</th>
<th>Mean [95% Conf-Int.]</th>
<th>Std.-Dev.</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘maximum’</td>
<td>7.0 [6.4;7.6]</td>
<td>2.6</td>
<td>7</td>
</tr>
<tr>
<td>Restrictions due to ear-ringing</td>
<td>Mean [95% Conf-Int.]</td>
<td>Std.-Dev.</td>
<td>Median</td>
</tr>
<tr>
<td>‘maximum’</td>
<td>5.8 [5.1;6.5]</td>
<td>3.0</td>
<td>6</td>
</tr>
</tbody>
</table>

137 patients (89%) were of wage-earning age, i.e. between 18 and 65 years. Table 1 shows that the duration of tinnitus was over 6 months for 80% of patients. 43.3% had been suffering from tinnitus for more than three years. 33.5% of those interviewed reported that tinnitus develops gradually. Every second patient (50.3%) said tinnitus sets in suddenly. 16.1% did not answer this question. 76.8% said tinnitus occurs continuously, and 21.3% reported that tinnitus occurs with interruptions. 3 patients (1.9%) had no comments. Almost all patients (94.8%) reported that there are times when tinnitus is particularly intense. In contrast, only 75.5% said that there are times when tinnitus makes itself barely perceptible.
Patients were also asked how often they resorted to facilities of the health care system over six months prior to treatment, and they had the option of several possible answers. 74 of patients answering this question reported 111 individual consultations (Main consultation: ENT-Specialists: 44.6%), which means an average of 1.5 consultations per patient approximately. Prior to treatment, patients were also asked about previous treatment. 137 patients reported a total of 304 instances, i.e. an average of 2.2 treatments per patient. The major treatments were infusions with 78.8%.

The total score of the TF at the different measurement points is shown in Figure 1.

The total sample as well as the sample reduced to follow-up participants were presented graphically in order to test the sample coherence. The fol-
low-up sample with regard to tinnitus does not differ significantly from the general population.

Figure 2 shows the mean scale values of the tinnitus questionnaire prior to and after the outpatient tinnitus therapy (N=146), and also at follow-up after 6 months (N=106).

**FIGURE 2.** Scale values prior to and after outpatient tinnitus therapy (N<sub>pre</sub>=146, N<sub>post</sub>=146, N<sub>follow-up</sub>=106). E: Emotional stress; C: cognitive stress; E+C: mental stress; I: Intensity of ear-ringing; A: auditive problems; SI: Sleep intensity; SO: somatic complaints.

In general, all subscales showed highly significant changes (t-test, p<0.01) between the measurement points “start of therapy” and “end of therapy”, while no significant differences were found between the measurement points “end of therapy” and “follow-up”. At follow-up, the values of the subscales are stabilized at a level recorded at the end of the

*Auditive Stimulation Therapy AST® as an intervention in subacute and chronic tinnitus.*
therapy; a reduction to the level prior to treatment was not observed. The scale items “emotional stress (E)” and “cognitive stress (C)”, and the combined subscale “mental stress” (E)+(C), indicated positive changes compared to values determined at the end of treatment. These differences, however, are not significant.

The values of effect sizes were determined for individual subscales, and the total score. The values for the effect sizes are all in the range of medium (>0.5) to high sizes (>0.8) – with the exception of the scale “somatic disorders” and are illustrated in Figure 3.

**FIGURE 3. Changes of scale values in effect sizes**

As the treatment concept presented in this study (Krefelder Modell) is a multimodal concept, the different elements of treatment have to be compared in order to achieve more detailed results on the efficiency of the
music therapy training programme (AST®). Kinesitherapy having received a distinctly lower rating by patients, only the two treatment elements rated as most successful were compared (psychological training PT – music therapy MT). The findings gained in this way were then used to draw conclusions on the significance of individual therapies for the entire therapy concept.

Comparing the individual therapies, music therapy training (AST®) was responsible for a surprisingly high percentage of the positive total result and clearly preferred by patients despite the fact that psychological training was twice as long (20 therapy sessions hours compared to 10 for music therapy). For further analysis of these findings, effect sizes at measurement times were calculated and related to the patients' subjective evaluation. The following graph illustrates the calculation of effect sizes. The most expressive results in this context certainly are those of the follow-up, since the data of these particular patients are available for all measurement times. In retrospective they were able to come to a conclusive evaluation for themselves.
Figure 4 indicates that a combination of MT and PT renders the best effects. MT alone is in second place, and PT third. The combination of MT=PT comprises the partial therapies MT and PT, and this suggests that the share of MT in this result is higher than that of PT. In addition, MT shows excellent effect sizes over longer periods as well; a clear indication of the quality of the concept of AST® as to contents and didactic implementation. The results appear to confirm in particular the intention to enable patients to continue independently with music therapy and to make autonomous use of receptive music programmes.

In answer to the question whether the therapy helped them to cope better with ringing in the ear, 40 % of patients described the success as "excellent", 29 % as good and 16,8 % as satisfactory. At a follow-up six months after the end of the therapy, the question was whether any ear ringing was still perceivable; 3,2 % of patients said none at all; 30.8% had a tempo-
Temporary absence of ear ringing; about two thirds of patients continued to perceive noises during the six months after the therapy ended; however, these had been clearly reduced. In summary, 52.3% indicated further positive changes after the therapy was concluded.

**Conclusion**

We were able to demonstrate that the multimodal concept evaluated (Krefelder Modell see Kusatz 2003) achieves highly significant changes. The calculation of effect size, according to the tinnitus questionnaires, illustrated that the most significant effect sizes occurred in the area of psychological stress and total score changes.

In comparison with studies into other therapies with hospitalized patients and out-patients, the advantages of a multimodal treatment concept has been amply demonstrated. The fact that the Krefelder Modell is the only concept to use the music therapy training programme, combined with the significance of this programme for the entire treatment concept, indicates that the advantage compared to other treatment forms is principally the consequence of the music therapy intervention (Kusatz 2003).

An analysis of the tinnitus problem, particularly from a traditional perspective, suggests a general confusion among most experts, although many scientists have explored the problem. A great variety of models and treatment approaches are available, the effectiveness of which are still inconclusive. The standard therapies in Germany include medication, to improve blood circulation or, with increasing frequency, infusions as part of a period in hospital, with disproportionate side effects compared to the severity of the complaints (Bork 2000). The question remains, “Why this helplessness in medical treatment of tinnitus”?

*Auditive Stimulation Therapy AST® as an intervention in subacute and chronic tinnitus.*
If we assume that tinnitus is not a disease but a symptom of an underlying process, then singular symptom orientated approaches will fail. 61% of patients state that professional medical help was of not much use – a shockingly high figure in view of the numerous medical interventions. There is much to suggest a holistic treatment approach and to see ringing in the ear as a sign of particularly high stress. The question whether the symptom is of a somatic, or a psychosomatic, nature seems to be of no importance in the treatment of subacute and chronic tinnitus. An analysis not only of the biological but also the psychological and social needs of patients provides a more comprehensive insight into and understanding of their situation (Aldridge 1998). Music therapy AST® is seen as salient to their problems among patients, and highly effective, perhaps because we are not directly making a singularly psychological intervention but an intervention in the same modus as the symptom is experienced. by accommodating sound control within an ecology of other sounds, itself within a stress reduction context, then we are offering a form of self control that is adapted to a personal environment (Aldridge 1996/1999). On this extended basis of our knowledge about hearing, it should be possible to develop coping strategies for patients that address the causes of the problem directly and thus render the symptom superfluous.

The subjective symptom of tinnitus is a phenomenon which persons not afflicted cannot easily understand, as it is difficult to define a cause in most cases. Hearing, or the auditory sense, normally directed to the outside, is suddenly directed internally and therefore hard to imagine for others. The sufferer suffers from a personal noise problem that is inaudible to others. Consequently, there is a lack of understanding on their part. For musicians, however, this is a concept that is easily understood (Neugebauer 2001). "Only inner anticipatory hearing makes musical interpretation possible. This phenomenon is most obvious in Ludwig van
Beethoven who composed without being able to hear. Accordingly, listening must also be seen as an internal process of perception”. Neugebauer (1999) reminds us that a sensory stimulation must not necessarily result in a conscious perception, nor must a sensory experience necessarily be caused by a physical stimulus. The specific way in which music therapists or musicians hear may indeed be helpful or suitable to understand tinnitus patients and also to explain – taking a composer as an example – how such experiences of internal hearing may also be observed in different settings where they are absolutely normal and by no means pathological. Aldridge (1996) suggests that the purpose of music therapy is that patients are enabled to generate expressive potentials, which reveal new possibilities for becoming healthy. In the context of ear ringing, music therapy might help to create a context of meanings which integrates the sounds or noises into the music and thus removes them from conscious perception, which would clearly promote recovery. Sounds, no longer perceived as disturbing, once brought under control, are perceived as musical.

This study demonstrates that music therapy is an effective treatment approach and offers a way to make progress in tinnitus treatment. Music has an aesthetic aspect, it is part of our cultural heritage. How we integrate sounds into our daily life, and how they become perceived as noise or music, is a complex activity involving the physiological, the psychological and the social. A therapeutic intervention that incorporates these understandings appears to offer considerable benefits, not as a cure but as a healthy adaptation.
References


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Music therapy in dementia care - Recent findings

Landsiedel-Anders, S., Music Therapist
BVM

Abstract

There has been an expressed need for studies in the area of dementia care from the German speaking countries (compare Grümme, 1998; nickel et al., 2002). This article presents the results from two recent studies. The first is a summative, internal evaluation of a music therapy intervention with six seriously demented male and female inhabitants of a nursing home for the elderly, based on qualitative and qualitative approaches. The second is a clinical experimental study with dementia patients at a medium stage as part of a memory-supporting surgery, a specific outpatient facility offering diagnostics, therapy and counselling to patients suffering from dementia.
1. Music therapy with seriously demented ward inmates

As part of a direct approach project arranged by the municipal authorities of Frankfurt/M. to improve the psychosocial care in nursing homes, four female and two male inmates (GDS grade 6 and 7) received music therapy sessions in small groups for a total of 40 hours over 7 months. The project was designed and evaluated in cooperation with this College of Advanced Technology in the department of social work and health. The assessment criteria of the intervention covered well-being, participation in musical activities and the ability to make contact. These were accompanied by observed recorded reactions made at certain intervals. These observations also included a section that documented specific single events recording qualitative changes over time. 40 recordings on mini discs were produced in addition, with 31 transcribed session protocols. Five evaluation categories were defined to cover general target fields in music therapy interventions with demented patients.

A descriptive statistical evaluation showed that reactions like laughter/smiling, singing/humming, swaying with the body, attentiveness, touching of instruments to producing sounds/notes, entering into contact with others or the music therapist were increased in frequency and duration.

The core case of the project report was that of a 65-year-old seriously demented man. He participated more purposefully in musical activities, there were positive changes related to psychomotoric unrest, an improvement in emotional satisfaction, an increase in communicative and contact abilities, as well as improvements in cognitive areas. In addition, a family member and a nurse, not involved in the project, found a slight improvement in his general mental state as a consequence of music therapy interventions. An abbreviated and edited version of the project report

2. Music therapy in dementia care – a clinical experimental study as part of a memory-supporting surgery

With a view to clinical practice, we selected a comparison study between music therapy and biographical work according to Selbst-Erhaltungs-Therapie SET (Romero, 1997). The study used a one-arm random trial plan with pre/post measurement. The treatment objectives were the possible effects of the two psychological intervention types on dementia disorders (medium stage), the extent of cognitive impairments, the extent of every-day competences, and the degree of non-cognitive accompanying symptoms. Test procedures applied were those common in dementia diagnostics and for progress examinations respectively (Global Deterioration Scale (GDS, Reisberg et al., 1982), Mini-Mental-Status-Test (MMST, Folstein et al., 1975), Clock-drawing test (modified according to Shulman et al., 1993), Instrumental Activity of Daily Living (IADL, Lawton and Brody, 1969) and Neuropsychiatric Inventory (NPI, Cummings et al., 1994)).

The random sample comprised 21 female and male patients of the memory-supporting surgery of the Clinic for Psychiatry and Psychotherapy I at the Johann Wolfgang Goethe University, Frankfurt/Main. They were between 55 and 84 years old. 12 of them were female (57%), the other nine male (43%). 12 patients suffered from dementia connected with Alzheimer’s Disease (57%), six from vascular dementia (29%), two from frontotemporal dementia (9%). Dementia was not confirmed in one test person (5%) in the course of the 15-week treatment; the patient was diagnosed with a continuing depressive disorder.
Since this was more an explorative study, for lack of comparative studies into the efficiency of psychological interventions, it focused on the presentation of descriptive results.

Inferential statistics calculations made for validation did not indicate any significant effects of music therapy on the symptoms of dementia mentioned above. However, a significant effect regarding biographical work was found with regard to the degree of dementia, and the effect even suggested an improvement.

Due to the small number of participants, among other things, the results of the inferential statistics calculations must be assumed to be limited in their significance. Moreover, the GDS as an assessment tool for a global grading of the degree of dementia did not register changes well and turned out to be prone to distortions in findings.

In general the data collected may also be carefully interpreted for both intervention types in such a way that despite the known progression in dementia, no significant changes occurred but no deterioration developed over four months.

This was confirmed at the descriptive level. Among the biographical work group, the level prior to intervention was maintained, and with the exception of the area of every-day competences, there were minor individual improvements in all other symptomatic areas. This is consistent with findings from comparable intervention studies.

In the pre/post comparison, the music therapy group showed no changes either with regard to the degree of dementia, cognitive impairments and every-day competences. Improvements emerged here in individual instances mainly in every-day cognitive abilities. This is all the more
astonishing and unexpected since major cognitive disturbances had been presented in the music therapy group.

These cognitive improvements detected objectively in patients were in contrast with the unchanged grading of the degree of dementia that were mainly based on external assessments. The latter was discussed in the context of the lower level of acceptance in family members in dealing with the slightly increased non-cognitive disorders that had also been explored in the study.

References


Odds and Ends - Themes and Trends

by Tom Doch

Hand-to-ear link in brain established after minutes of piano learning

Source: http://www.alphagalileo.org/

09 October 2003


Contrary to what your music teacher told you, it does not take decades of piano practice to learn to play phrases on the piano without looking at your fingers. A brain map linking finger movements with particular notes begins to form within minutes of starting training, according to research published this week in BMC Neuroscience.

Recent brain imaging studies of professional musicians have demonstrated that silent tapping of musical phrases can stimulate auditory areas
of the cortex and hearing music can stimulate areas of the motor cortex. Moreover, according to anecdotal evidence, hearing music can cause pianists to move their fingers involuntarily.

To find out how fast links between these two brain areas could be formed Marc Bangert and Eckart Altenmüller, from the Institute of Music Physiology and Musicians’ Medicine in Hanover, examined the effects on the brain of taking up a musical instrument from scratch. Their results showed that patterns of brain activity when listening to music or silently tapping a keyboard could be altered after just 20 minutes of piano practice. These changes were enhanced after five weeks of training.

Two groups of beginner pianists undertook ten 20-minute training sessions over the course of five weeks. In these sessions they learned to play back musical phrases they heard on a digital piano. No visual or verbal cues like tone names or score notation, or even their own hands visible on the piano keys, were allowed during training. This policy ensured that the training exercise involved only auditory and motor skills.

The two groups differed slightly in their training regime. The first group (the ‘map’ group) used digital pianos where the five neighbouring keys had appropriate notes assigned to them.

The second group (the ‘no-map’ group) used pianos where the assignment of notes to the five keys was ‘shuffled’ after each training trial.

The researchers explain: ‘The ‘no-map’ group was not given any chance to figure out any coupling between fingers and notes, except the temporal coincidence of keystroke and sound. In other words: these subjects were
not given any opportunity to establish an internal ‘map’ between motor events and auditory pitch targets.’’

Before and after the first session and after the fifth and tenth sessions the novice pianists were asked to listen passively to short musical phrases and, in a separate test, to arbitrarily press keys on a soundless piano keyboard.

During these test sessions the researchers monitored the electrical activity of the students’ brains in 30 different places using a technique called electroencephalography. This enabled the researchers to build up maps of brain activity.

The patterns of brain activity after five sessions varied considerably between the two groups.

For example the ‘map’ group activated the motor area for the hand when they were listening to music, whereas the ‘no-map’ group did not.

The researchers also identified another area of the brain, in the right anterior region, which was more active in the ‘map’ group than the ‘non-map’ group. This area could be where the note to piano key ‘map’ is established.

Previous research has suggested that this area is involved in the perception of melodic and harmonic pitch sequences. Bangert says, ‘Interestingly, the respective area in the left hemisphere is where you would find Broca’s area, where much of our speech processing happens.’’

OUTDOORLINKS: This release is based on the following article: Mapping perception to action in piano practice: a longitudinal DC-EEG study
Decreased Latent Inhibition Is Associated With Increased Creative Achievement

BMC Neuroscience 2003, Published 15th October 2003

http://www.biomedcentral.com/1471-2202/4/26

Eckart O Altenmüller

http://www.hmt-hannover.de/studium/lehrende/index.htm

Institute of Music Physiology and Musicians’ Medicine in Hanover

http://www.immm.hmt-hannover.de/

source: http://www.apa.org/journals/psp/903ab.html

Reductions in latent inhibition (LI), the capacity to screen from conscious awareness stimuli previously experienced as irrelevant, have been generally associated with the tendency towards psychosis. However, "failure" to screen out previously irrelevant stimuli might also hypothetically contribute to original thinking, particularly in combination with high IQ.
Meta-analysis of two studies, conducted on youthful high-IQ samples, demonstrated that high lifetime creative achievers had significantly lower LI scores than low creative achievers.

Eminent creative achievers (participants under 21 years who reported unusually high scores in a single domain of creative achievement) were 7 times more likely to have low rather than high LI scores.

OUTDOORKLINK: Jordan B. Peterson, Ph.D. Department of Psychology, University of Toronto

http://www.psych.utoronto.ca/~peterson/welcome.htm

But OHSU researcher says jump in BDNF, neurogenesis may not be beneficial


Exercise enthusiasts have more reasons to put on their running shoes in the morning, but an Oregon Health & Science University scientist says they shouldn't step up their work-outs just yet.

A study published today in the journal Neuroscience, journal of the International Brain Research Organization, confirmed that exercise increases the chemical BDNF – brain-derived neurotrophic factor – in the hippocampus, a curved, elongated ridge in the brain that controls learning and memory.

BDNF is involved in protecting and producing neurons in the hippocampus.

"When you exercise, it's been shown you release BDNF," said study co-author Justin Rhodes, Ph.D., a postdoctoral fellow in the Department of Behavioral Neuroscience at OHSU's School of Medicine and at the Veterans Administration Medical Center in Portland.

"BDNF helps support and strengthen synapses in the brain. We find that exercise increases these good things."

Mice bred for 30 generations to display increased voluntary wheel running behavior – an "exercise addiction" – showed higher amounts of BDNF than normal, sedentary mice. In fact, the BDNF concentration in the active mice increased by as much as 171 percent after seven nights of wheel running.

"These mice are more active than wild mice," Rhodes said, referring to the mice as small and lean, and seemingly "addicted" to exercise. "Wheel running causes a huge amount of activity in the hippocampus. The more running, the more BDNF."
In a study Rhodes also co-authored that extends these findings, to be published in the October edition of the American Psychological Association journal Behavioral Neuroscience, scientists demonstrated that not only do the mice display more of this "good" BDNF chemical in the hippocampus, they grow more neurons there as well.

But those high levels of BDNF and neurogenesis don't necessarily mean an exercise addict learns at a faster rate, Rhodes said. According to the Behavioral Neuroscience study, the running addict, compared with the normal-running, control mice, perform "terribly" when attempting to navigate around a maze.

"These studies are focusing on the effects of exercise itself on chemicals known to protect and strengthen synapses," Rhodes explained. "But too much of it is not necessarily a good thing."

High runners tend to "max out" in the production of the BDNF and neurogenesis, Rhodes said. And that topping-out effect may be what prevents learning.

A high-running mouse's inability to learn as well as a normal mouse could be due to less biological reasons, Rhodes points out. "It is possible that they're so focused on running, they can't think of anything else," he said.

Rhodes and colleagues at the University of Wisconsin at Madison, the University of California at Riverside and The Salk Institute also emphasize that the functional significance of the exercise-induced increases in BDNF and neurogenesis is not known.
Rhodes suggests that when a high-running mouse exercises, stress is placed on its hippocampus and the development of new neurons becomes a protective response. No one has yet tested whether hyperactive wheel running exercise actually kills or damages neurons in the hippocampus, he said.

"The reason why these good things are happening is they may clean up some of the mess," he said. "Knowing that, you wouldn't expect high runners to get any benefit from it."

One thing is clear: Exercise greatly activates the hippocampus. Rhodes and his colleagues have conducted research that also shows the intensity of exercise is linearly related to the number of neurons that are activated in a subregion of the hippocampus called the dentate gyrus.

In addition, they have demonstrated that when mice are kept from their normal running routine, brain regions involved in craving for natural rewards such as food, sex and drugs of abuse become activated. It is allowing Rhodes to study the relationship between natural craving, like hunger, and drug craving due to a pathological addiction.

"The point is to characterize what makes drug craving different from natural craving at the level of the genes and neuronal substrates involved so that, eventually, a pharmaceutical therapy can be designed to target the pathology," Rhodes said.

CONTACT: Jonathan Modie

modiej@ohsu.edu

503-494-8231
High Blood Pressure Does Not Accelerate Age-Related Cognitive Decline

Oregon Health & Science University

OUTDOORLINKS: Brain-derived neurotrophic factor (BDNF)


Oregon Health & Science University

http://www.ohsu.edu/

The Journal of Neuroscience

http://www.jneurosci.org/

High Blood Pressure Does Not Accelerate Age-Related Cognitive Decline

Source: dukemednews.org/ 9.29.2003

Duke University Medical Center researchers have found that contrary to the classical model of aging, increased blood pressure does not accelerate the age-related decline in performing certain mental tasks.

Furthermore, the researchers reported, middle-aged subjects with high blood pressure showed more of a slowing in cognitive performance tests than did older adults with high blood pressure.

According to the researchers, past studies have been epidemiological in nature and have hinted that hypertensive patients perform worse than individuals with normal blood pressure on cognition tests, as measured by the speed of mental processing, attention, and memory tasks. However, unlike the new Duke study, which was performed in a laboratory setting, previous studies have been unable to tease out relationships between elevated blood pressures and age on specific cognitive tasks.

The results of the Duke experiments were published today (Sept. 29, 2003) in the September issue of the journal Aging, Neuropsychology and Cognition. The study was supported by the National Institutes of Health.

"While the changes in cognitive performance associated with elevated blood pressure seen in our experiments were statistically significant, they are unlikely to interfere with mental functioning during everyday life," said Duke's David Madden, Ph.D., cognitive psychologist and researcher in aging.

"However, the changes we recorded in the laboratory may represent a situation that could become clinically significant when other diseases, especially those that are cardiovascular in nature, are included."
"The significance of these cognitive effects will become clearer as additional evidence is obtained regarding the changes in brain structure and function that typically accompany chronically elevated blood pressure," Madden said.

Unlike the previous studies, where patients often had other diseases and might have been on medications, the Duke team focused exclusively on participants who had high blood pressure, but who were not taking any medications. None of the participants had detectable cardiovascular disease.

"We know that in general, hypertension increases with age," Madden said. "Our goal was to determine if there was any effect of elevated blood pressure on the natural course of healthy aging."

For their experiments, the Duke team recruited 96 adult volunteers – 48 with unmedicated high blood pressure and 48 with normal blood pressure. The patients were then equally divided into three groups: young (20-39), middle-aged (40-59) and older (60-79). Blood pressures were taken at regular intervals throughout the course of the experiments.

The tests, which were taken on a personal computer, measured how quickly participants could correctly respond in two general areas – visual search tasks and memory search tasks. In both cases, the stimuli on the computer screen were different combinations of 20 white consonants on a black background.

For the visual search tasks, participants had to view a pair of letters, and then after a period of time, had to quickly determine which one of that pair was present within displays of four to six letters. For the memory...
task, participants viewed either four or six letters, and then after a period of time, two letters appeared on the screen. Participants had to indicate which one of the letters was within the original group. Each participant underwent 640 trials.

"The results of our experiments show that the interaction between the effects of blood pressure and adult age do not support the predictions of the classical model, which holds that increasing blood pressure accelerates the decline in intelligence tasks," Madden said. "Our analysis of response times found that a decline in the high blood pressure group was only evident for the middle-aged group, but not for the youngest or oldest participants."

Additionally, the team found that increasing age was associated with specific deficits in performing search tasks above and beyond what would have been expected, whereas increasing blood pressure was not associated with these deficits, Madden continued.

The differences in performance between the high blood pressure group and the normal blood pressure group were more closely related to the overall level of difficulty of the task rather than to short-term memory demands, he added.

Duke colleagues on the study were Linda Langley, Rebecca Thurston, Wythe Whiting, Ph.D. and James Blumenthal, Ph.D.

**CONTACT SOURCES:**

David Madden, (919) 660-7537

Djm@geri.duke.edu
Affective style and in vivo immune response: Neurobehavioral mechanisms

Considerable evidence exists to support an association between psychological states and immune function. However, the mechanisms by which such states are instantiated in the brain and influence the immune system are poorly understood.

The present study investigated relations among physiological measures of affective style, psychological well being, and immune function.

Negative and positive affect were elicited by using an autobiographical writing task. Electroencephalography and affect-modulated eye-blink startle were used to measure trait and state negative affect.

Participants were vaccinated for influenza, and antibody titers after the vaccine were assayed to provide an in vivo measure of immune function. Higher levels of right-prefrontal electroencephalographic activation and greater magnitude of the startle reflex reliably predicted poorer immune response. These data support the hypothesis that individuals characterized by a more negative affective style mount a weaker immune response.
Presynaptic kainate receptors impart an associative property to hippocampal mossy fiber long-term potentiation

and therefore may be at greater risk for illness than those with a more positive affective style.

Read Fulltext (PDF)

"AFFECTIVE STYLE AND IN VIVO IMMUNE RESPONSE: NEUROBEHAVIORAL MECHANISMS" by Melissa A. Rosenkranz, Richard J. Davidson und Mitarbeitern

http://ntp.neuroscience.wisc.edu/faculty/fac-art/davidson100.pdf

Presynaptic kainate receptors impart an associative property to hippocampal mossy fiber long-term potentiation


Hippocampal mossy fiber synapses show an unusual form of long-term potentiation (LTP) that is independent of NMDA receptor activation and is expressed presynaptically.

Using receptor antagonists, as well as receptor knockout mice, we found that presynaptic kainate receptors facilitate the induction of mossy fiber
Presynaptic kainate receptors impart an associative property to hippocampal long-term potentiation (LTP), although they are not required for this form of LTP.

Most importantly, these receptors impart an associativity to mossy fiber LTP such that activity in neighboring mossy fiber synapses, or even associational/commissural synapses, influences the threshold for inducing mossy fiber LTP. Such a mechanism greatly increases the computational power of this form of plasticity.

Correspondence should be addressed to R A Nicoll. e-mail: nicoll@phy.ucsf.edu

OutDoorLinks:

Dietmar Schmitz

http://www.charite.de/schmitzlab/

Dr. Jack Mellor

http://www.bris.ac.uk/neuroscience/research/groups/assocdetails/73

Jörg Breustedt

http://www.charite.de/schmitzlab/joerg.htm
The Sounds of Science

What's the sound of two molecules touching?


http://www.the-scientist.com/yr2003/sep/upfront1_030922.html

Ask James La Clair and Michael Burkart, two University of California, San Diego, scientists, who recently developed a biosensor on the surface of an ordinary compact disc. Data from a CD is nothing more than a stream of 1s and 0s, the digital representation of how laser light reflects off the disc's aluminum platter. Any dust or scratch on the CD's surface produces errors in the playback; La Clair reasoned that biomolecules would do so as well.

After experimenting with music CDs, the team turned to data CDs. They assigned a string of bytes to represent each ligand (they used biotin and mannose), and then burned those bytes onto the disc. The data's geographical location guided an inkjet printer, which coated the disc's appro-
The Sounds of Science

Appropriate region with the molecules. The disc was then mixed with sample, washed, and played; errors in the data stream represented molecular interactions. "The molecules can actually act as if they're Mozart" by changing the resulting notes, says La Clair.

Click to hear an audio file before (438K) and after (436K) ligand binding. (Scroll down to find the URLs in our OutDoorLinks!)

Burkart and La Clair say they're not out to dethrone microarray technology; their printing resolution is inferior, and the CDs have fewer features.

But, because CD players are ubiquitous, and cheap, they see a future in next-generation home diagnostics, such as high-tech pregnancy tests.

Jeffrey M. Perkel


OUTDOORLINKS:

Full Text: Molecular screening on a compact disc

http://www.rsc.org/CFmuscat/dire_ecomm.cfm?REDURL=/ej/OB/2003/b306391g/index.htm&VOLNO=%26nbsp%3B%3Cb%3E1%3C%2Fb%3E&Yr=2003&Pp=3244&Ep=3249&Journal-Code=OB&Iss=18&CFID=380447&CFTOKEN=2887882

Article: Scientists develop novel way to screen molecules using conventional CDs and compact disk players
New international society has been formed


University of California, San Diego


Sound before

http://www.the-scientist.com/sound/yr2003/sep22/without01.wav

Sound after

http://www.the-scientist.com/sound/yr2003/sep22/with01.wav

New international society has been formed

The Goal: To provide a forum for the exchange of research and clinical ideas relating to all aspects of normal and disordered speech, language, and hearing
An international society has been formed to provide a forum for the exchange of research and clinical ideas relating to all aspects of normal and disordered speech, language, and hearing.

This society, called the Asia Pacific Society for the Study of Speech, Language and Hearing, was formed following the 2nd Asia Pacific Conference on Speech, Language and Hearing (held at the Gold Coast, Australia), and has, to date, drawn members from a wide range of countries including China, Nepal, Malaysia, USA, Australia and New Zealand.

I would like to take this opportunity to invite you to become a member of this new and exciting society.

For an annual membership fee of AUD $140 you will receive:

1) a full year’s subscription to the Asia Pacific Journal of Speech, Language and Hearing

2) discount registration to the 4th Asia Pacific Conference on Speech, Language and Hearing, which is being held in conjunction with the 26th IALP Congress in Brisbane, Australia 2004

3) a sixth monthly newsletter relating to speech, language and hearing events in the Asia-Pacific rim

4) access to an email discussion group
New international society has been formed

If you would like to find out more about this Society please contact Justine Goozee at j.goozee@uq.edu.au (Ph +61 7 3365 3097), who is the Secretary/Treasurer of the Society.

A website is available, which provides further details regarding the Society and the Asia Pacific Journal of Speech, Language and Hearing:


I look forward to welcoming you to membership of the Society.

Yours sincerely,

Professor Bruce E. Murdoch

President, Asia Pacific Society for the Study of Speech, Language and Hearing

School of Health and Rehabilitation Sciences, The University of Queensland, Australia

OUTDOORLINKS:

Asia Pacific Society for the Study of Speech, Language and Hearing


School of Health and Rehabilitation Sciences

http://www.shrs.uq.edu.au/
EU calls for more and better co-ordinated brain research at European level

Professor Bruce Murdoch, BSc(Hons), PhD, DSc

http://www.uq.edu.au/~uqshrs1/school_staff/bruce_murdoch.html

EU calls for more and better co-ordinated brain research at European level

source: alphagalileo.org 18 September 2003

Some 250 leading brain specialists are gathering in Brussels today to discuss the creation of a European Brain Research Area. European Research Commissioner Philippe Busquin opened the conference on ‘Brain Research in Europe: Structuring European Neuroscience’, which was organised together with Member of the European Parliament Giuseppe Nistico.

Representatives from the scientific community, including academia and industry, public administrations, research funding bodies, patients’ organisations, European institutions and the media are exchanging views on priorities and modalities for a stronger and more coherent effort for brain research in Europe.

The European Commission announced that it is negotiating new projects for brain research to be launched in 2004 for a total of approximately €45 million. Brain research and neurosciences are explicit research topics
in the EU’s 6th Framework Programme, the EU’s financial instrument for creating a European research area.

‘In this field like in many other fields of research, Europe is faced with a costly paradox,’ said Research Commissioner Philippe Busquin. ‘Europe has world-class brain researchers who interact on an individual basis across Europe. Yet, those that fund brain research hardly interact, let alone that they co-ordinate investments at a European level. The brain and neurosciences are a field where Europe can do much more by working better together. The brain is at the origin of human intelligence and creativity. At the same time, brain disorders are the cause of suffering and pain for many patients. Is it not surprising how little we know about the brain and how little awareness there is among the public of the health benefits and economic development that brain research can bring?’

Brain research develops basic knowledge in areas such as molecular and cellular neuroscience, developmental neurobiology, neurogenetics, sensory physiology, ethology and cognitive neuroscience. It also focuses on pre-clinical and clinical research into neurological and psychiatric disorders and diseases such as Alzheimer’s disease Parkinson’s, depression and schizophrenia. Degenerative diseases such as Alzheimer’s and Parkinson’s affect thousands of Europeans and are difficult to cure. Mental disorders inflict pain, disrupt lives and place a heavy burden on European society.

Europe needs fundamental neuroscience research
EU calls for more and better co-ordinated brain research at European level

The top priority in this sector is to develop new and better means of diagnosis and therapy of neurological and psychiatric disorders and diseases, such as Parkinson’s, or bipolar disorders. All progress in this field comes from the knowledge provided by fundamental neuroscience research. Furthermore, basic research, as a driving force behind the European effort in neuroscience research, will provide a new insight into mental processes in general.

Brain researchers working together

The burdens and costs of brain disorders, on individuals and society as a whole, are very high and pose a major challenge to European health care systems. Most scientists’ national organisations involved in brain research have already agreed to co-operate more closely, pooling resources in bodies such as the ‘Federation of European Neuroscience Societies’ (FENS) or the ‘European Federation of Neurological Societies’ (EFNS). They address some of the weaknesses of European neuroscience research, but fragmentation of investments and under-funding still prevail.

Several of these organisations recently agreed to form the European Brain Council (EBC), which should provide a more comprehensive umbrella organisation for all societies or bodies concerned with brain research in Europe. This would include various patient associations, such as the European Federation of Neurological Associations (EFNA).

Creating a European Brain Research Area
The conference, organised at the initiative of the European Commission, aims to foster the creation of a truly European Research Area (ERA) in the field of brain research. The conference should make recommendations on how to streamline and better co-ordinate brain research funding across Europe. The conference will also discuss how the EU can catalyse such an effort, in particular through the EU’s research funding programme (the 6th Research Framework Programme, FP6, 2003-2006).

FP6 will devote €2,255 billion to health-related research, including neuroscience. The Commission is currently negotiating new integrated projects and networks of excellence, resulting from a first call for proposals, that address depression, neuropathology of ataxias, protein aggregation in neurodegenerative diseases and human brain tissue. Smaller projects are expected to address rare neurological disorders and pain. The mobilisation of the scientific community to FP6’s first call for proposals, following a massive input of research ideas last year, demonstrates its consciousness and willingness to create a true European research area in their field. Only so will Europe be able to overcome the fragmentation in neuroscience research in Europe and eventually forge ahead of the US and Japan.

In the longer term, other new promising technologies supported by FP6, such as nanotechnologies, could help tackle brain diseases, for instance with nanosensors to identify and cure damaged brain cells. FP6 also provides innovate schemes such as the ERANET, which supports the coordination of national and regional research programmes.

The conference
The conference offers a unique opportunity,

- to provide a forum to the various stakeholders (including representatives from the scientific community, public administration, foundations, patients’ organisations, industry, European institutions, decision-makers and the media) to discuss the organisation of European brain research in respect of basic and clinical/applied research at national and European levels;
- to report major trends and initiatives in European brain research and future expectations;
- to explore opportunities for the main stakeholders in brain research to work more closely together and to agree on the way forward;

...to raise public awareness on brain/neuroscience research.

The conference took place at the Centre A. Borschette, room 0/A, rue Froissart 36 in Brussels starting on 18 September 2003, at 9:00.

OUTDOORLINKS: For further information on the conference (including the full programme)


For the thematic priority on life sciences, genomics and biotechnology for health in the Sixth Framework Programme (FP6)

EU calls for more and better co-ordinated brain research at European level

Web pages of the European Brain Council (EBS)

http://www.europeanbraincouncil.com/news.htm

Scientific officers

Philippe Cupers, Major Diseases Unit,
DG Research
Tel: +32.2.299 87 96
E-mail: Philippe.Cupers@cec.eu.int

Jürgen Sautter, Major Diseases Unit,
DG Research
Tel: +32.2.299 87 35
E-mail: Juergen.Sautter@cec.eu.int

Commissioner Busquin’s Spokesman

Fabio Fabbi, Spokesman for Research Commissioner Philippe Busquin,
Convolution is one of the most common operations in image processing.

Based on experimental findings on motion-sensitive visual interneurons of the fly, we show by realistic compartmental modeling that a dendritic network can implement this operation.
In a first step, dendritic electrical coupling between two cells spatially blurs the original motion input. The blurred motion image is then passed onto a third cell via inhibitory dendritic synapses resulting in a sharpening of the signal. This enhancement of motion contrast may be the central element of figure–ground discrimination based on relative motion in the fly.

This paper was submitted directly (Track II) to the PNAS office.

* To whom correspondence should be addressed. E-mail: cuntz@neuro.mpg.de.

For humans, social cues often guide the focus of attention. Although many nonhuman primates, like humans, live in large, complex social groups, the extent to which human and nonhuman primates share fundamental mechanisms of social attention remains unexplored.

Here, we show that, when viewing a rhesus macaque looking in a particular direction, both rhesus macaques and humans reflexively and covertly orient their attention in the same direction. Specifically, when performing a peripheral visual target detection task, viewing a monkey with either its eyes alone or with both its head and eyes averted to one
side facilitated the detection of peripheral targets when they randomly appeared on the same side.

Moreover, viewing images of a monkey with averted gaze evoked small but systematic shifts in eye position in the direction of gaze in the image. The similar magnitude and temporal dynamics of response facilitation and eye deviation in monkeys and humans suggest shared neural circuitry mediating social attention.

OUTDOORLINKS:

Current Biology

https://www.current-biology.com/

Deaner, Robert

http://www.primates.wisc.edu/pin/idp/wdp/entry/1584

Michael Platt, Ph.D.

http://www.neuro.duke.edu/Faculty/Platt.htm

Duke Universitaet in Durham/Duke Neurobiology

http://www.neuro.duke.edu/
**Sensory cells for hearing and balance are fast-developing, UVA researchers find**

Source: [www.eurekalert.org](http://www.eurekalert.org), 14-Sep-2003

The functional development of hair cells in the inner ear that mediate hearing and balance takes place over a period of just one day in mouse embryos, according to a study by a research team at the University of Virginia Health System.

The U.Va. scientists found that three essential elements for development in the mouse inner ear appear between day 16 and day 17 of gestation, roughly equivalent to the late second trimester or early third trimester in the human fetus. The finding is important for ongoing research on regeneration of sensory hair cells in the human inner ear, say researchers, writing in the October edition of Nature Neuroscience, found online at [www.nature.com/neuro](http://www.nature.com/neuro).

"We were surprised that development of hair cells in the inner ear takes place so rapidly," said researcher Jeffrey R. Holt, an assistant professor of neuroscience and otolaryngology at U.Va. "Suddenly, the hair cells began working. To eventually discover how to regenerate hair cells in the human ear, we have to know when and how the original hair cells develop. That's why this research is so central to our knowledge."

The next challenge for scientists is to discover the molecular "switches" that turn on inner ear hair cells. "Scientists at U.Va. and elsewhere are working to test stem cells to see if they can develop into hair cells," Holt
Sensory cells for hearing and balance are fast-developing, UVA researchers find

said. "If we can find the molecular process, we can potentially turn another cell type into an inner ear hair cell."

The researchers said they are now assembling a list of processes these important cells go through to develop correctly. "We know the sequence," said study co-author Gwénaëlle Géléoc, an assistant professor of neuroscience and otolaryngology. "Now we can look at different cell types and see if they are on the right track to produce hair cells."

In the lab, Holt and Géléoc found that hair cell transduction in mice, or the response to movement of hair bundles associated with hearing, begins to function over a 24 hours period, starting at embryonic day 16.

Interestingly, all three essential elements develop simultaneously: membrane-bound transduction channels, like trap doors, are formed to carry calcium and potassium which together create an electrical charge sending hearing and balance signals to the brain; microscopic tip-links are formed that operate under tension to open the trap door channel; finally, tiny adaptation motors are formed that regulate sensitivity and allow sounds that range from a faint whisper to a booming cannon to be heard.

The authors of the study said their work may mean a better understanding of congenital hearing and balance deficits in humans.

CONTACT: Bob Beard

reb8e@virginia.edu

434-982-4490

University of Virginia Health System
Inside the brain of a taxi driver

OUTDOORLINKS:

University of Virginia Health System

http://hsc.virginia.edu/

Nature Neuroscience

http://www.nature.com/neuro/

Jeffrey R. Holt

http://www.healthsystem.virginia.edu/internet/otolaryngology/physicians.cfm


http://www.alphagalileo.org/index.cfm?fuseaction=readRelease&ReleaseID=15205&ts=e3RzICcyMDAzLTA5LTEyIDExOjQzOjQwJ30=

London cabbies are famed for their navigational abilities, but how do they do it?
Inside the brain of a taxi driver

Research in this week's Nature shows how landmarks and locations can trigger key brain cells into action.

Michael J. Kahana and Itzhak Fried and colleagues persuaded human volunteers to play a taxi-based computer game. Driving around in a virtual town, subjects had to search for passengers and deliver them to various shops.

As they did so, the team measured the activity of key neurons in the subjects' brains. Neurons in the hippocampus—an area implicated in learning and memory—responded to particular locations.

Cells in a different area, the parahippocampal cortex responded more to landmarks.

The research shows how we use a network of neurons to aid navigation.

Similar cells have been identified in the rodent brain, but this is the first time they have been demonstrated in human subjects.

CONTACT:

Michael J. Kahana (Brandeis University, Waltham MA, USA)
Tel: +1 781 736 3253, E-mail: kahana@brandeis.edu

Itzhak Fried, M.D., Ph.D. (University of California at Los Angeles, CA, USA)
Tel: +1 310 825 8409, E-mail: ifried@mednet.ucla.edu
Timing sleep and wakefulness

OUTDOORLINKS:

Michael J. Kahana

http://memlab1.ccs.brandeis.edu/~kahana/

Itzhak Fried

http://www.neurosurgery.medsch.ucla.edu/Faculty/Fried/
Faculty_Fried.html

Download a high quality video of the Yellow-Cab game (123 MB).

http://fechner.ccs.brandeis.edu/research/yellowcab.mpg

nature journal

http://www.nature.com/

Timing sleep and wakefulness


A circadian clock within the brain ensures that we sleep at night and are awake during the day. But as anyone who has stayed up all night and
fallen into a deep sleep the next morning knows, the timing of sleep also depends on the need for sleep.

Now a paper in the October issue of Nature Neuroscience reports that sleep homeostatic processes, which cause the urge to sleep to depend on prior amounts of sleep or wakefulness, influence the circadian clock.

Johanna Meijer and colleagues monitored the vigilance state of rats by recording their brain (EEG) and muscle (EMG) signals. At the same time, the experimenters recorded neuronal activity within a brain region called the suprachiasmatic nucleus (SCN) to monitor the output of the circadian clock.

Driven by cycles of gene transcription and translation, activity in the SCN normally oscillates with day and night cycles. They found a clear correlation between vigilance states and activity in the SCN.

Furthermore, by using sleep deprivation experiments, they tested for a casual relationship. Indeed, during sleep deprivation, neuronal activity in the SCN failed to show expected changes in electrical activity for the time of day, demonstrating that activity in the SCN is determined not only by the molecular machinery of the circadian clock, but also by sleep need.

A next step will be to determine how changes in need for sleep are communicated to the SCN at the molecular level.

**AUTHOR CONTACT:** Johanna Meijer (University of Leiden, The Netherlands)
A uniquely specialized ear in a very early tetrapod

Tel: +31 71 527 67 15; E-mail: J.H.Meijer@lumc.nl

Additional contact for comment on paper:

Christopher Colwell (University of California at Los Angeles, Los Angeles, CA, USA.)

Tel: +1 310 206 3973; E-mail: ccolwell@mednet.ucla.edu

A uniquely specialized ear in a very early tetrapod

source: nature.com 4 September 2003


The Late Devonian genus Ichthyostega was for many decades the earliest known tetrapod, and the sole representative of a transitional form between a fish and a land vertebrate.

However, despite being known since 1932 (ref. 1) from a large collection of specimens, its morphology remained enigmatic and not what was expected of a very primitive tetrapod. Its apparent specializations led it to be considered as a "blind offshoot" or "sidebranch" off the tetrapod family tree, and recent cladistic analyses have disagreed about its exact phylogenetic position within the tetrapod stem group.

In particular, its braincase and ear region defied interpretation, such that conventional anatomical terms seemed inapplicable. Using new material
collected in 1998 (ref. 9), preparation of earlier-collected material, and high-resolution computed tomography scanning, here we identify and interpret these problematic anatomical structures. They can now be seen to form part of a highly specialized ear, probably a hearing device for use in water.

This represents a structurally and functionally unique modification of the tetrapod otic region, unlike anything seen in subsequent tetrapod evolution. The presence of deeply grooved gill bars as in its contemporary Acanthostega suggest that Ichthyostega may have been more aquatically adapted than previously believed.

OUTDOORLINKS:
The Shape of Life – Jenny Clack

http://www.pbs.org/kcet/shapeoflife/explorations/bio_clack.html

Jenny Clack - Early Tetrapod Research at the University of Cambridge, England

http://www.palantir.fsnet.co.uk/

Nature

http://www.nature.com/
New research reveals corporations increasingly make employees face the music

Pop music is used to create place and exercise power

Source: www.eurekalert.org 4-Sep-2003

Forget performance related pay and flexi-time, new research by Martin Corbett from Warwick Business School reveals large corporations increasingly use hip pop music to develop loyal, hard-working employees, and encourage workers, literally, to sing from the same hymn sheet. However, despite encouragement, not all employees dance to the same tune.

Company songs, from IBM's rehash of a US fighting song to NCR's rendition of the Beatle's 'Back in the USSR', typically reinforce senior management's definition of corporate culture and extol the virtues of team effort to employees, or promote corporate brand to external stakeholders such as potential customers.

Corbett's research paper on company song lyrics and style entitled "I Sing the Body (In)Corporate", reveals that companies are taking cover versions to the extreme by incorporating tunes and phrases from well-known Gospel and pop songs into new compositions. Hewlett Packard's contribution to pop is a reworking of the band Pink's worldwide hit 'Get the Party Started', and AT&T heavily borrowed from Sister Sledge's million selling disco album 'We are Family'.

Pop music is used to create place and exercise power, and upbeat company songs stress youthful exuberance, teamwork and ability to respond to customers. And it's not only American and Japanese corporations that
New research reveals corporations increasingly make employees face the

are employing 'aural branding', Asda, Price WaterhouseCoopers, McKinsey and KPMG are all getting in the groove.

However, it's certainly not always the case that songs entice employees to readily identify with their company and unite. While sing-along marching songs, as used by Wal Mart, induce positive feeling and happiness, so help control employee behaviour, songs are also used subversively to provide resistance to work. In fact, many 'official' songs are received with cynicism by employees, or even result in embarrassment.

Although songs or music can help branding and team building, a number of company songs, especially those in the style of Gospel anthems, such as 'Ahh Fujitsu', inspire dysfunction amongst employees. Fujitsu's attempt to get employees to join in a Japanese style sing-song using sheet music failed when few could read sheet music.

Without control over the placement and timing of anthems, company music runs the risk of ridicule. For example, KPMG's anthemic, but now cringe worthy, 'Vision of Global strategy' was copied in mp3 format by employees, remixed, and distributed on the net.

Martin Corbett, Researcher with Warwick Business School, said: "Many insights into corporate culture are given by lending an ear to organisational practice. However, it's only when the reproduction of a company song, its location, timing and performance is firmly managed can Executives ensure their intentions aren't distorted. Motivational songs are still, at times, derided as nonsense and employees can be cynical about ageing companies trying to gain the respect of youths by linking to Platinum albums."
Staying healthy may involve more than washing hands or keeping a positive attitude. According to a study from the University of Wisconsin-Madison, it also may involve a particular pattern of brain activity.
By monitoring activity levels in the human brain's prefrontal cortex, the researchers demonstrate for the first time that people who have more activity in the left side of this area also have a stronger immune response against disease. The findings, soon to be published in the Proceedings of the National Academy of Sciences, pinpoint one of the mechanisms underlying the link between mental and physical well-being.

Numerous scientific studies show that keeping a positive attitude can keep a person healthy, says Richard Davidson, a UW-Madison neuroscientist and senior author of the paper. But he adds that the reasons why this connection exists are poorly understood.

By turning to the brain - an organ that sends signals that guide emotional response - Davidson and his group have identified one possible explanation: activity in the prefrontal cortex, a region of the brain long associated with affective style, or how a person responds emotionally to an event.

"Emotions play an important role in modulating bodily systems that influence our health," says Davidson. "We turned to the brain to understand the mechanisms by which the mind influences the body."

While earlier studies have linked emotional and physical health, as well as brain activity and affective style, Davidson says none have established a direct link between brain activity and immune function.

The latest study by the UW-Madison group demonstrates this connection.

For the study, the researchers worked with 52 individuals between the ages of 57 and 60 who were recruited from the Wisconsin Longitudinal Study - a long-term study of more than 10,000 people who graduated from Wisconsin high schools in 1957. Specifically, the scientists wanted
Left Side Of Brain Influences Immune Function

to know if people who showed more activity in the left side of the prefrontal cortex - a part of the brain associated with positive emotional responses - also showed greater immunity to the influenza virus after vaccination.

To answer this question, the researchers vaccinated all the subjects against the flu virus. Before vaccination, they measured the study participants' brain activity, both at a baseline state and during emotion eliciting memory tasks. During these tasks, the participants were asked to recall two events - one that made them feel intensely happy and another that left them feeling intensely sad, fearful or angry. As the respondents focused on the emotion experienced for one minute, the researchers measured the electrical activity in both the right and left sides of the prefrontal cortex.

Previous studies, notes Davidson, have shown that individuals with greater activity on the right side of this brain region tend to have a more negative affective style, which can cause these individuals to respond inappropriately to emotional events.

The researchers collected these prefrontal cortex activity levels again after the subjects spent five minutes writing about the particular events. At this time, they also measured the participants' eyeblink reflex in response to sudden noises. This measure, explains Davidson, provides a convenient and objective way to measure how negatively or positively a person reacts to a stimulus.

Three times in the six months following vaccination, the researchers collected serum samples from each subject to track the number of flu-fighting antibodies in the blood, which can determine immune function.
Six months after being vaccinated against the flu virus, the subjects who had greater activity in the left side of the prefrontal cortex, instead of the right side, also had a greater rise in the number of antibodies for influenza, says Davidson.

"This study establishes that people with a pattern of brain activity that has been associated with a positive affective style are also the ones to show the best response to the flu vaccine," says the Wisconsin researcher. "It begins to suggest a mechanism for why subjects with a more positive emotional disposition may be healthier."

**OUTDOORLINKS:**

Anatomie und Funktionsweise des Gehirns

http://www.m-ww.de/krankheiten/prionenkrankheiten/anatomie_hirn.html

Richard Davidson

http://psych.wisc.edu/faculty/bio/davidson.html

Laboratory for Affective Neuroscience

http://psyphz.psych.wisc.edu/
What happens when a music therapist participates in a conference of the European Society for the Cognitive Sciences of Music? Well, she seems to get a lot of inspiration and sees very interesting and useful research, - and sometimes she is astonished about which kind of research some people are investigating time and money in. In the following you will find a thoughts and impressions from the conference where there were a huge
number of presentations with a common theme on cognitive science of music, and here seen from a music therapeutic perspective.

**FIGURE 1. Hanne Mette Ridder Ochsner**

In music therapy research we are strongly dependant on research in music perception and production, psychoacoustics, neurological aspects of musical experience, emotional effects of music, musical identities, and evaluative, regulative, and communicative aspects of musical influence. And the other way round; it might be important to cognitive sciences of music when music therapy research shows evidence of effects of music with client groups of many kinds.
On this 5th ESCOM conference there were one symposium and 3 thematic sessions on music therapy. The music therapy symposium was organized by Jörg Fachner from University of Witten/Herdecke in Germany and consisted of 7 papers that mainly were related to certain client groups and methods of music therapy in this connection. In the symposium following themes were presented: “Temporal, occipital and parietal EEG-brain-mapping changes in pre/post-THC-music and rest” (Jörg Fachner), “Phillips Groove! – integrating young children with autism on childcare playgrounds” (Petra Kern), “Music therapy with people suffering from multiple sclerosis: an interdisciplinary pilot study” (Wolfgang Schmidt), “Auditive Stimulation Therapy AST®. Intervention in sub-acute and chronic tinnitus” (Martin Kusatz), “Phrasing as expression of time and timing in improvised music therapy” (Peter Hoffmann), “Communication and dialogue – Music therapy with persons in advanced stages of dementia” (Hanne Mette Ridder), and “Relations between
tempo performance, expressiveness, and music therapy outcome” (Veronika Busch).

FIGURE 3. After the presentation ... (from left to right: Hanne Mette Ridder, Petra Kern, Martin Kusatz, Jörg Fachner and ESCOM guest Patriccia Sabbatella )

The music therapy symposium only attracted about 20-40 persons, so it is clear that music therapy is a small niche on this conference. All together, 270 papers were accepted at the conference with authors from 34 countries. Music therapy research seems to get stronger and stronger if we consider the increasing number of accepted dissertations and take into account that a new research field like music therapy need to define new methodologies. On the conference as a whole I met both sceptical remarks on music therapy research, and remarks showing interest in the field, but at the symposium the comments and questions to the presenters were mostly of a very positive kind, showing that the concrete papers
might have settled with some of the prejudices on this research discipline.

FIGURE 4. Wolfgang Schmid and Christine Plahl

A symposium that I found interesting for the music therapy field was titled ‘Emotion regulatory processes and musical development’ and organized by Stefanie Stadler Elmer from Switzerland. In her opening presentation (‘Well-being, children’s vocal play, and musical development’) she focused on children’s spontaneous singing or vocal play, and from analyses on audio- or video data she concluded that children seem to be able to use singing unconsciously to recreate previous experiences and emotional states. This presentation was followed by Christine Plahl from Germany that I already had the nice opportunity to hear on the World Conference of music therapy in Oxford in 2002. Her work with
video micro analysis focussing on intentionality, intensity, and self-confidence, and on coherence, synchronicity, and reciprocity is very interesting and useful to music therapy research. The title of her presentation was ‘Fostering the development of social-emotional communication through music’ with data based on music therapy interventions with 12 multiple handicapped children. She concluded that the details of the video micro analysis reveal how the music therapist creates the musical environment, and that this zone of proximal development is characterised by a specific set of musical features and a special form of therapeutic co-regulation.

Next Christliebe El Mogharbel presented the case of Samantha. From her 3rd to her 15th year instances of singing were recorded and transcribed. This material showed that the autistic girl’s musical ability in singing developed although she never developed verbal language. In music therapy literature there is focus on clinical work with clients in the autistic spectrum and the methodological aspects of this study might be interesting to many clinicians. Registering musical production (singing) over time, with in-depth analyses of song material (here with focus on their similarity with well known children’s songs) gave an example of a longitudinal case study model with focus on single aspects, - aspects that in music therapy research would be issues that are relevant to the music therapy treatment.

Apart from the music therapy symposia there were thematic sessions on music therapy. Two of these were about the beneficial effects of choir singing. Gunter Kreutz analyzed sIgA and cortisol levels in saliva from 23 female amateur choir singers and confirmed positive emotional and immunogenetic effects of group singing. Next Bailey and Davidson elaborated on previous research where they investigated the participation of
homeless and disadvantaged individuals in an amateur choir. They wanted to further validate the findings with larger numbers of singers in choirs in more common environments (church, community, and workplace). Their results – based on participant ratings – indicate that participation in group singing may be more beneficial than less active types of music involvement. A great number of music therapists include group singing and singing in individual therapy in their work (see Ridder 2003) which means that research in choir singing offers additional arguments for singing in/as therapy. – And actually the theme “singing” was seen in more papers. Inge Cordes from University of Bremen, Germany, analysed different forms of melodic contour, e.g. rising contours that are used to arouse attention, and falling contours that we see in e.g. lullabies. She sees a correspondence of pitch contours in songs and melodic contours of motherese. Beatriz Ilari from the Infant Speech Perception Lab in Montréal, Canada, saw that 8-month-old children, especially the girls, preferred a cappella songs compared to complex musical textures.
When people sing together it is characteristic that they sing simultaneous, unlike speech where people mostly take turns. Apart from this, musical and verbal communication has much in common and Nicholas Bannan from University of Reading, UK, proposed that musical communication represented the bridge between animal communication and human language. His research integrated evidence from various fields, and in a chronology of archaeological evidence he started 6 million years ago in
Tugen hills in Kenya with species that walk on two legs (a posture affecting the vocal tract, larynx, and sound of voice) until 100,000 years ago where language and vocalization became central to human behaviour. In his keynote presentation Bjorn Merker from Uppsala University in Sweden among other things took a starting point in synchronized singing, and argued for human singing as a biological adaptation – illustrated by wonderful examples of animal “singing”, e.g. gibbon females.

Even if a person suffering from prosopagnosia without aphasia is not able to name the face of Ronald Reagan, the person might be able to see that there is a connection between the faces of Ronald and Nancy Reagan. Similarly persons suffering from amusia without aphasia might be able to connect cords that are harmonically related than less related cords. From this Barbara Tillmann from University of Lyon in France concluded that implicit knowledge of harmonic structures might remain intact and accessible, even when explicit judgments and overt recognition have been lost. This result is important to music therapy with client groups with different cognitive deficits. Even if they seem to fail in melodic and temporal musical tests their implicit knowledge is relevant and might give them access to music and musical experiences. Spared implicit knowledge was not, as I see it, taken into account in the subsequent paper about music perception in patients with dementia due to Alzheimer’s Disease. 16 persons with AD at a mild to moderate level were compared to a group of young people and a group of normal elderly adults. Their reaction in simple music units and sound parameters as well as in complex music patterns and melodies were tested, showing that persons with AD exhibit a decrease in the number of correct answers regarding mainly the perception of differences in volume and rhythm. The testing was done with help of a computer, with computer sounds and with non-familiar melodies, and I wonder what important information we lose in test situa-
tions like this, working with persons that have cognitive deficits such as lapse of memory, and orientation and concentration disturbances. But it is an interesting observation that the persons with AD scored higher on test in melody and timbre, suggesting that melodic forms, and hereby tuneful songs, are perceptible…

Unfortunately it is impossible to refer to all the interesting papers that I had the possibility to attend. The ESCOM-5 conference was long, starting on Monday and ending on Saturday with 12 parallel paper sessions on most days plus a daily keynote presentation and poster presentations. If you want more information, all papers presented at the conference are published on CD by Hanover University of Music and Drama (ISBN: 3-931852-67-9. ISSN: 1617-6847. See www.escom5.de).

Representing different angle of approaches, following keynote speakers presented their work: Timothy D. Griffiths, Tia de Nora, Helga de la Motte-Haber, Simha Arom, Björn Merker, and Holger Höge.
In the evenings wonderful concerts were arranged. Among these Trần Quang Hai from Vietnam gave me an unforgettable evening. It was amazing how this man could control the overtones of his voice and could isolate and change these. He showed his ethnomusical knowledge by imitating many different ways of singing and using the voice from bel canto to yodel, and in showing astonishing skills in the simplest forms of instruments, such as the Jew’s harp and spoon playing. The audience not only had the audible input from his singing and playing, but visually could follow the spectre of his voice on a tone frequency analyser. His way of exploring, playing and improvising with the simplest instruments – including the voice – was a wonderful example of how infinite musical expression is when it is connected with playfulness. Our perception of
music can be so very restricted and limited by our expectations to genre and sound. What we hear as a single tone is much more than pitch and sound waves, and might be perceived in very other ways.

And who would expect that you could play techno music with a Jew’s harp?